



HEALTH SCIENCES LIBRARY  
UNIVERSITY OF MARYLAND  
BALTIMORE







Digitized by the Internet Archive  
in 2016

<https://archive.org/details/imjillinoismedic1511illi>





# Illinois Medical Journal

OFFICIAL JOURNAL OF THE  
ILLINOIS STATE MEDICAL SOCIETY

Volume 151/Number 1

January 1977

HEALTH SCIENCES LIBRARY  
UNIVERSITY OF MARYLAND  
BALTIMORE

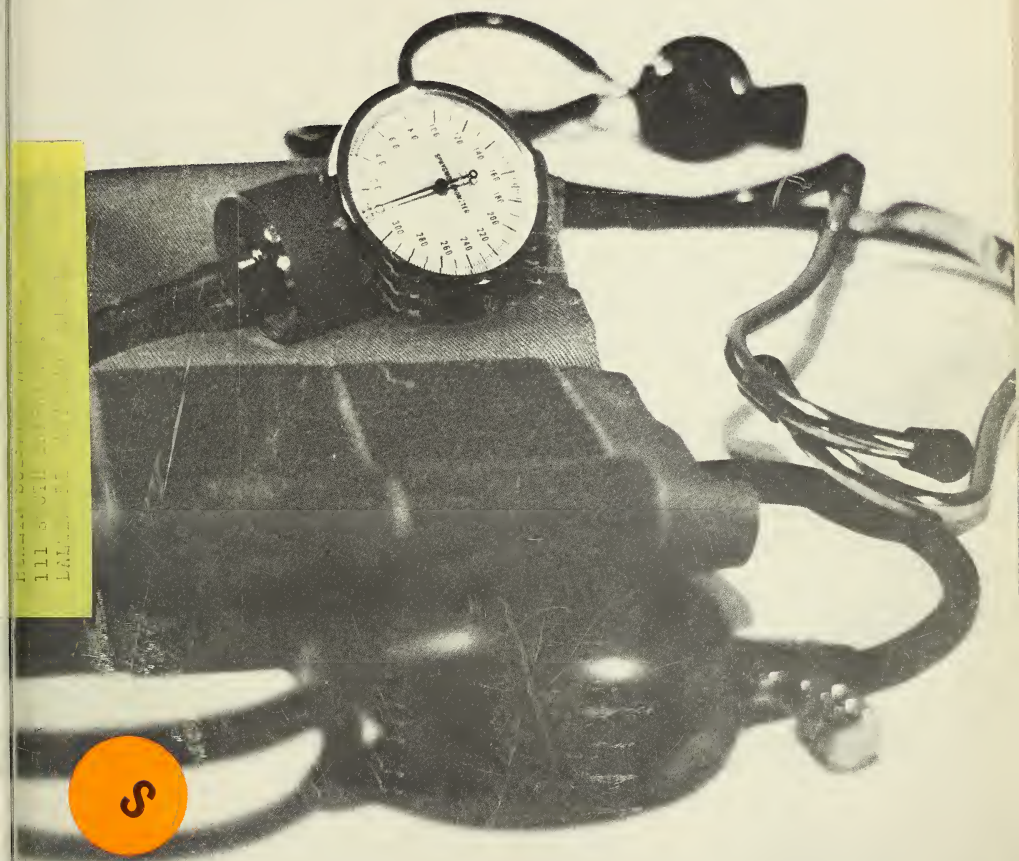
JAN 25 '77

REC'D

FEB 11 '77

STACKS

STACKS



S

Table of Contents . . . 3

President's Page . . . 61

Opinion Poll . . . 38

**HYPERTENSION**  
Review of Treatment . . . 25

# BURROUGHS WELLCOME CO. MAKES CODEINE COMBINATION PRODUCTS.

## YOU MAKE THE CHOICE.

HEALTH SCIENCES LIBRARY  
UNIVERSITY OF MARYLAND  
BALTIMORE



### EMPIRIN<sup>®</sup> COMPOUND c̄ CODEINE #3

Each tablet contains:  
codeine phosphate, 32 mg (gr ½),  
(Warning: May be habit-forming);  
aspirin, 227 mg; phenacetin, 162 mg;  
and caffeine, 32 mg.



### EMPRACET<sup>™</sup> c̄ CODEINE #3

Each tablet contains:  
codeine phosphate, 30 mg (gr ½),  
(Warning: May be habit-forming);  
and acetaminophen 300 mg.



Wellcome

Burroughs Wellcome Co.  
Research Triangle Park  
North Carolina 27709





## Illinois Medical Journal

---

JANUARY, 1977

Vol. 151, No. 1

CONTENTS

---

- 10 Abstracts of Board Actions
- 

### *Convention Summary*

- 51 Summary of House of Delegates Actions  
55 Actions on Resolutions
- 

### *Clinical Articles*

- 21 Increased Safety in Renal Transplantation  
*J. Laurance Hill, M.D., Simon J. Simonian, M.D.  
and Frank P. Stuart, M.D./Chicago*
- 25 Current Treatment of Essential Hypertension  
*Louis C. Johnston, M.D./Chicago*
- 31 School Screening for Scoliosis  
*Daniel C. Newman, M.D. and Ronald L. DeWald, M.D./Chicago*
- 39 Adolescent Solvent Abuse  
*William E. Thornton, M.D./Chicago*
- 

### *Surgical Grand Rounds*

- 44 Case Report: Liver Tumor  
*John M. Beal, M.D., Editor*
- 

### *President's Page*

- 61 The Constitution: Our Greatest Ally  
*Joseph H. Skom, M.D.*
- 

(Contents continued on overleaf)



## Features

- 8 Editorial
- 17 EKG of the Month
- 18 Obituaries
- 38 Doctor—What's Your Opinion?
- 42 Viewbox
- 47 Clinics for Crippled Children
- 48 ISMS Guide to Continuing Medical Education
- 59 Doctor's News
- 65 Membership Forum
- 66 Illinois Society, American Association of Medical Assistants
- 68 Guest Editorial
- 69 New Pharmaceutical Specialties
- 71 Pulse of the Doctor's Wife
- 72 Physician Recruitment

## Staff

Managing editor ..... Richard A. Ott

Assistant editor ..... Mariann McGuire

Executive administrator ..... Roger N. White

(Cover photo by Ed Steckl)

## PUBLICATIONS COMMITTEE

Jacob E. Reisch, M.D., Springfield, *Chairman*

Lawrence L. Hirsch, M.D., Chicago

Alfred J. Kiessel, M.D., Decatur

Warren D. Tuttle, M.D., Harrisburg

Herman Wing, M.D., Chicago

Contributor in Surgery: John M. Beal, M.D., Chicago

Contributor in Internal Death Studies:

Robert Hartman, M.D., Jacksonville

Contributor in Pediatric Perplexities: Ruth Andrea Seeler, M.D., Chicago

Contributor in Radiology: Leon Love, M.D., Maywood

Contributor in Cardiology: John R. Tobin, M.D., Maywood

Contributor in Immunopathology: Richard J. Ablin, Ph.D., Chicago

## ILLINOIS STATE MEDICAL SOCIETY

### OFFICERS

Joseph Skom, M.D., President

707 Fairbanks Ct., Chicago 60611

George Wilkins, M.D., President-Elect

3165 Myrtle, Granite City 62040

David S. Fox, M.D., 1st Vice-President

826 E. 61st St., Chicago 60637

Theodore Grevas, M.D., 2nd Vice-President

2701 17th St., Rock Island 61201

Jacob E. Reisch, M.D., Secretary-Treasurer

1129 S. 2nd St., Springfield 62704

### HOUSE OF DELEGATES

James A. McDonald, M.D., Speaker of the House

515 Oakwood Dr., Geneva 60134

Cyril C. Wiggishoff, M.D., Vice Speaker

25 E. Washington, Suite 1805, Chicago 60602

### TRUSTEES

1st District: 1977, Joseph L. Bordenave, M.D.

415 S. Second St., Geneva 60134

1A District: 1977, P. John Seward, M.D.

2400 N. Rockton, Rockford 61101

2nd District: 1977, Allan L. Goslin, M.D.

712 N. Bloomington, Streator 61364

3rd District: 1979, Alfred Clementi, M.D.

675 W. Central Rd., Arlington Heights 60005

3rd District: 1977, Alfred J. Faber, M.D.

2100 Swainwood Dr., Glenview 60025

3rd District: 1979, Robert T. Fox, M.D.

2136 Robin Crest, Glenview 60025

3rd District: 1978, Henrietta Herbolsheimer, M.D.

5528 S. Hyde Park Blvd., Apt. 1202, Chicago 60637

3rd District: 1978, Lawrence L. Hirsch, M.D.

2434 Grace, Chicago 60618

3rd District: 1978, Eugene T. Hoban, M.D.

6429 North Ave., Oak Park 60302

3rd District: 1977, William M. Lees, M.D.

6518 North Nokomis, Lincolnwood 60466

3rd District: 1977, Joseph C. Sherrick, M.D.

303 E. Superior, Chicago 60611

3rd District: 1977, Philip G. Thomsen, M.D.

13826 Lincoln Ave., Dolton 60419

3rd District: 1979, Herman Wing, M.D.

400 E. Randolph, Chicago 60601

4th District: 1979, Fred Z. White, M.D.

723 N. 2nd St., Chillumco 61523

5th District: 1979, Paul F. Mahon, M.D.

326 N. 7th St., Springfield 62702

6th District: 1978, Robert R. Hartman, M.D.

1515 A. W. Walnut, Jacksonville 62650

7th District: 1979, Alfred J. Kiessel, M.D.

1800 E. Lake Shore Dr., Decatur 62521

8th District: 1979, James Laidlaw, M.D.

104 W. Clark, Champaign 61820

9th District: 1978, Warren D. Tuttle, M.D.

203 N. Vine St., Harrisburg 62946

10th District: 1978, Julian W. Buser, M.D.

6600 W. Main, Belleville 62223

11th District: 1977, Ross N. Hutchison, M.D.

126 E. Ninth St., Gibson City 60936

Trustee-At-Large: J. M. Ingalls, M.D.

502 S. Shaw, Paris 61944

Chairman of the Board: Robert T. Fox, M.D.

2136 Robincrest, Glenview 60025

Microfilm copies of current as well as some back issues of the *Illinois Medical Journal* may be purchased from Xerox University Microfilm, 300 North Zeeb Road, Ann Arbor, Mich. 48106.

Contents of *IMJ* are listed in the *Current Contents/Clinical Practice*.

Published by the Illinois State Medical Society, 55 E. Monroe St., Chicago, Ill. 60603 (312-782-1654)

Copyright, 1977. The Illinois State Medical Society.

Subscription \$8.00 per year, in advance, postage prepaid, for the United States, Cuba, Puerto Rico, Philippine Islands and Mexico. \$10.00 per year for all foreign countries included in the Universal Postal Union. Canada \$8.50, U.S. Single current copies available at \$1.00 (\$1.10 by mail), back issues \$1.50.

Second class postage paid at Chicago, Ill. When moving please notify Journal office of new address including old mailing label with notification, if possible. POSTMASTER: Send notice on form No. 3579 to Illinois State Medical Society, 55 E. Monroe St., Chicago, Ill. 60603.

Pharmaceutical advertising must be approved by the ISMS Publications Committee. Other advertising accepted after review by Publications Committee or Board of Trustees. All copy or plates must reach the Journal office by the fifteenth of the month preceding publication. Rates furnished upon request.

Original articles will be considered for publication with the understanding that they are contributed only to the *Illinois Medical Journal*. The ISMS denies responsibility for opinions and statements expressed by authors or in excerpts, other than editorial or allied views or statements which reflect the authoritative action of the ISMS or of reports on official actions, policies or positions. Views expressed by authors do not necessarily represent those of the Society; any connection with official policies is coincidental.

The *Illinois Medical Journal* is published by the Illinois State Medical Society as an educational and professional informational magazine and distributed as a benefit of membership in the Illinois State Medical Society. Its intent is to keep members current in medical knowledge and is a part of a continuing medical education program. Socioeconomic matters, affecting as they do a changing pattern in the proper delivery of medical care, are considered an inherent element in medical education.





## Illinois Medical Journal

FEBRUARY, 1977

Vol. 151, No. 2

CONTENTS

---

90 ISMS Leadership Conference

---

### *Clinical Articles*

- 103 Effective Treatment of Diabetic Retinopathy  
*Peter H. Morse, M.D./Chicago*
- 106 Rheumatoid Myopathy  
*Paul E. Kaplan, M.D./Chicago*
- 110 Pseudomonas Lumbar Diskitis  
*Abdul R. C. Amine, M.D. and Jose L. Salazar, M.D./Chicago*
- 113 Cardiac Valve Replacement: Improved Survival Related to  
Air Exclusion and Myocardial Protection  
*S. C. Balderman, M.D., R. J. Bates, M.D., M.Phil., and  
C. E. Anagnostopoulos, M.D./Chicago*
- 117 Unusual Popliteal Mass  
*James Hill, M.D., Joseph A. Caprini, M.D. and  
William J. Dawson, M.D./Evanston*
- 121 A Decerebrate Patient: Eighteen Years of Care  
*Robert E. Field, M.D. and Raymond J. Romanus, M.D./  
Blue Island and Harvey*
- 125 Pelvic Lipomatosis  
*Joseph F. Norfray, M.D., Lawrence Schlachter, M.D.  
and William J. Heiser, M.D./Chicago*
- 

### *Special Articles*

- 135 Alcoholism—Outpatient and Follow-Up Treatment in a General Hospital  
*Helen K. Cooley, B.A./Evergreen Park*
- 

### *Surgical Grand Rounds*

- 128 Case Report: Adrenal Tumor  
*John M. Beal, M.D., Editor*
- 

### *President's Page*

- 133 Fraud  
*Joseph H. Skom, M.D.*
- 

(Contents continued on overleaf)

## Features

- 86 Editorial
- 92 Membership Forum
- 96 Obituaries
- 99 Illinois Society, American Association of Medical Assistants
- 100 Clinics for Crippled Children
- 101 EKG of the Month
- 131 Doctor's News
- 140 ISMS Guide in Continuing Medical Education
- 142 Physician Recruitment
- 144 Pulse of the Doctor's Wife
- 145 New Pharmaceutical Specialties

## Staff

Managing editor ..... Richard A. Ott  
 Assistant editor ..... Mariann McGuire  
 Executive administrator ..... Roger N. White

(Cover by Alicia Albanese Kolton)

## PUBLICATIONS COMMITTEE

Jacob E. Reisch, M.D., Springfield, *Chairman*  
 Lawrence L. Hirsch, M.D., Chicago  
 Alfred J. Kiesel, M.D., Decatur  
 Warren D. Tuttle, M.D., Harrisburg  
 Herman Wing, M.D., Chicago

Contributor in Surgery: John M. Beal, M.D., Chicago  
 Contributor in Maternal Death Studies:  
 Robert Hartman, M.D., Jacksonville  
 Contributor in Pediatric Perplexities: Ruth Andrea Seeler, M.D., Chicago  
 Contributor in Radiology: Leon Love, M.D., Maywood  
 Contributor in Cardiology: John R. Tobin, M.D., Maywood  
 Contributor in Immunopathology: Richard J. Ablin, Ph.D., Chicago

## ILLINOIS STATE MEDICAL SOCIETY

### OFFICERS

Joseph Skom, M.D., President  
 707 Fairbanks Ct., Chicago 60611  
 George Wilkins, M.D., President-Elect  
 3165 Myrtle, Granite City 62040  
 David S. Fox, M.D., 1st Vice-President  
 826 E. 61st St., Chicago 60637  
 Theodore Grevas, M.D., 2nd Vice-President  
 2701 17th St., Rock Island 61201  
 Jacob E. Reisch, M.D., Secretary-Treasurer  
 1129 S. 2nd St., Springfield 62704  
**HOUSE OF DELEGATES**  
 James A. McDonald, M.D., Speaker of the House  
 515 Oakwood Dr., Geneva 60134  
 Cyril C. Wiggishoff, M.D., Vice Speaker  
 25 E. Washington, Suite 1805, Chicago 60602

### TRUSTEES

1st District: 1977, Joseph L. Bordenave, M.D.  
 415 S. Second St., Geneva 60134  
 1A District: 1977, P. John Seward, M.D.  
 2400 N. Rockton, Rockford 61101  
 2nd District: 1977, Allan L. Goslin, M.D.  
 712 N. Bloomington, Streator 61364  
 3rd District: 1979, Alfred Clementi, M.D.  
 675 W. Central Rd., Arlington Heights 60005  
 3rd District: 1977, Alfred J. Faber, M.D.  
 2100 Swainwood Dr., Glenview 60025  
 3rd District: 1979, Robert T. Fox, M.D.  
 2136 Robin Crest, Glenview 60025  
 3rd District: 1978, Henrietta Haselbolzheimer, M.D.  
 5528 S. Hyde Park Blvd., Apt. 1202, Chicago 60637  
 3rd District: 1978, Lawrence L. Hirsch, M.D.  
 2434 Grace, Chicago 60618  
 3rd District: 1978, Eugene T. Hoban, M.D.  
 6429 North Ave., Oak Park 60302  
 3rd District: 1977, William M. Lees, M.D.  
 6518 North Nokomis, Lincolnwood 60064  
 3rd District: 1977, Joseph C. Sherrick, M.D.  
 303 E. Superior, Chicago 60611  
 3rd District: 1977, Philip G. Thomsen, M.D.  
 13826 Lincoln Ave., Dolton 60419  
 3rd District: 1979, Herman Wing, M.D.  
 400 E. Randolph, Chicago 60601  
 4th District: 1979, Fred Z. White, M.D.  
 723 N. 2nd St., Chilloicthe 61523  
 5th District: 1979, Paul F. Mahon, M.D.  
 326 N. 7th St., Springfield 62702  
 6th District: 1978, Robert R. Hartman, M.D.  
 1515 A. W. Walnut, Jacksonville 62650  
 7th District: 1979, Alfred J. Kiesel, M.D.  
 1800 E. Lake Shore Dr., Decatur 62521  
 8th District: 1979, James Laidlaw, M.D.  
 104 W. Clark, Champaign 61820  
 9th District: 1978, Warren D. Tuttle, M.D.  
 203 N. Vine St., Harrisburg 62946  
 10th District: 1977, Julian W. Buser, M.D.  
 6600 W. Main, Belleville 62223  
 11th District: 1977, Ross N. Hutchison, M.D.  
 126 E. Ninth St., Gibson City 60936  
 Trustee-At-Large: J. M. Ingalls, M.D.  
 502 Shaw, Paris 61944  
 Chairman of the Board: Robert T. Fox, M.D.  
 2136 Robincrest, Glenview 60025

Microfilm copies of current as well as some back issues of the *Illinois Medical Journal* may be purchased from Xerox University Microfilm, 300 North Zeeb Road, Ann Arbor, Mich. 48106.

Contents of *IMJ* are listed in the *Current Contents/Clinical Practice*. Published by the Illinois State Medical Society, 55 E. Monroe St., Chicago, Ill. 60603 (312-782-1654). Copyright, 1977. The Illinois State Medical Society.

Subscription \$8.00 per year, in advance, postage prepaid, for the United States, Cuba, Puerto Rico, Philippine Islands and Mexico. \$10.00 per year for all foreign countries included in the Universal Postal Union. Canada \$8.50. U.S. Single current copies available at \$1.00 (\$1.10 by mail), back issues \$1.50.

Second class postage paid at Chicago, Ill. When moving please notify Journal office of new address including old mailing label with notification, if possible. POSTMASTER: Send notice on form NO. 3579 to Illinois State Medical Society, 55 E. Monroe St., Chicago, Ill. 60603.

Pharmaceutical advertising must be approved by the ISMS Publications Committee. Other advertising accepted after review by Publications Committee or Board of Trustees. All copy or plates must reach the Journal office by the fifteenth of the month preceding publication. Rates furnished upon request.

Original articles will be considered for publication with the understanding that they are contributed only to the *Illinois Medical Journal*. The ISMS denies responsibility for opinions and statements expressed by authors or in excerpts, other than editorial or allied views or statements which reflect the authoritative action of the ISMS or of reports on official actions, policies or positions. Views expressed by authors do not necessarily represent those of the Society; any connection with official policies is coincidental.

The *Illinois Medical Journal* is published by the Illinois State Medical Society as an educational and professional informational magazine and distributed as a benefit of membership in the Illinois State Medical Society. Its intent is to keep members current in medical knowledge and is a part of a continuing medical education program. Socioeconomic matters, affecting as they do a changing pattern in the proper delivery of medical care, are considered an inherent element in medical education.





## Illinois Medical Journal

MARCH, 1977

Vol. 151, No. 3

CONTENTS

---

### *Convention Program*

- |     |  |
|-----|--|
| 195 | Members of the 1977 House of Delegates |
| 196 | Delegates and Alternates               |
| 198 | Officers of County Medical Societies   |
| 203 | Program Summary by Days                |
| 204 | Auxiliary Convention Program           |
| 205 | Agenda of the House of Delegates       |
| 207 | Committees of the House of Delegates   |
| 209 | Resolutions                            |
- 

### *Clinical Articles*

- |     |  |
|-----|--|
| 177 | Group B Beta Hemolytic Streptococcal Infection in Neonates<br><i>Ronald Turner, M.D., and Ronald E. Keeney, M.D./<br/>Columbus, Ohio and Springfield</i> |
| 181 | Propanolol in Attempted Suicide<br><i>Antonio Boba, M.D., and Kenneth A. Peart, M.D./Mt. Vernon</i>  |
| 183 | St. Louis Encephalitis: Clinical Course and Response to Corticosteroids<br><i>Curtis M. Sauer, M.D./ Urbana</i>  |
- 

### *Special Articles*

- |     |   |
|-----|---|
| 187 | Actions of the Department of Registration and<br>Education Medical Disciplinary Board |
|-----|---|
- 

### *President's Page*

- |     |   |
|-----|---|
| 190 | "We Have Met the Enemy and They Is Us"<br><i>Joseph H. Skom, M.D.</i> |
|-----|---|

(Contents continued on overleaf)



## Features

- 156 Editorial
- 166 EKG of the Month
- 170 Viewbox
- 172 Obituaries
- 174 Clinics for Crippled Children
- 191 Doctor's News
- 219 Pulse of the Doctor's Wife
- 220 Membership Forum
- 225 Illinois Society, American Association of Medical Assistants
- 226 Physician Recruitment
- 229 ISMS Guide to Continuing Medical Education

## Staff

- Managing editor ..... Richard A. Ott
- Assistant editor ..... Mariann McGuire
- Executive administrator ..... Roger N. White

(Cover by Mary Hill and Marc Simon)

## PUBLICATIONS COMMITTEE

- Jacob E. Reisch, M.D., Springfield, *Chairman*
- Lawrence L. Hirsch, M.D., Chicago
- Alfred J. Kiessel, M.D., Decatur
- Warren D. Tuttle, M.D., Harrisburg
- Herman Wing, M.D., Chicago

- 
- Contributor in Surgery: John M. Beal, M.D., Chicago
  - Contributor in Maternal Death Studies:  
Robert Hartman, M.D., Jacksonville
  - Contributor in Pediatric Perplexities: Ruth Andrea Seeler, M.D., Chicago
  - Contributor in Radiology: Leon Love, M.D., Maywood
  - Contributor in Cardiology: John R. Tobin, M.D., Maywood
  - Contributor in Immunopathology: Richard J. Ablin, Ph.D., Chicago

## ILLINOIS STATE MEDICAL SOCIETY

### OFFICERS

- Joseph Skom, M.D., President  
707 Fairbanks Ct., Chicago 60611
- George Wilkins, M.D., President-Elect  
3165 Myrtle, Granite City 62040
- David S. Fox, M.D., 1st Vice-President  
826 E. 61st St., Chicago 60637
- Theodore Grevas, M.D., 2nd Vice-President  
2701 17th St., Rock Island 61201
- Jacob E. Reisch, M.D., Secretary-Treasurer  
1129 S. 2nd St., Springfield 62704

### HOUSE OF DELEGATES

- James A. McDonald, M.D., Speaker of the House  
515 Oakwood Dr., Geneva 60134
- Cyril C. Wiggishoff, M.D., Vice Speaker  
25 E. Washington, Suite 1805, Chicago 60602

### TRUSTEES

- 1st District: 1977, Joseph L. Bordenave, M.D.  
415 S. Second St., Geneva 60134
- 1A District: 1977, P. John Seward, M.D.  
2400 N. Rockton, Rockford 61101
- 2nd District: 1977, Allan L. Goslin, M.D.  
712 N. Bloomington, Streator 61364
- 3rd District: 1979, Alfred Clementi, M.D.  
675 W. Central Rd., Arlington Heights 60005
- 3rd District: 1977, Alfred J. Faber, M.D.  
2100 Swainwood Dr., Glenview 60025
- 3rd District: 1979, Robert T. Fox, M.D.  
2136 Robin Crest, Glenview 60025
- 3rd District: 1978, Henrietta Herbolzheimer, M.D.  
5528 S. Hyde Park Blvd., Apt. 1202, Chicago 60637
- 3rd District: 1978, Lawrence L. Hirsch, M.D.  
2434 Grace, Chicago 60618
- 3rd District: 1978, Eugene T. Hoban, M.D.  
6429 North Ave., Oak Park 60302
- 3rd District: 1977, William M. Lees, M.D.  
6518 North Nokomis, Lincolnwood 60064
- 3rd District: 1977, Joseph C. Sherrick, M.D.  
303 E. Superior, Chicago 60611
- 3rd District: 1977, Philip G. Thomsen, M.D.  
13826 Lincoln Ave., Dolton 60419
- 3rd District: 1979, Herman Wing, M.D.  
400 E. Randolph, Chicago 60601
- 4th District: 1979, Fred Z. White, M.D.  
723 N. 2nd St., Channahon 61523
- 5th District: 1979, Paul F. Mahon, M.D.  
326 N. 7th St., Springfield 62702
- 6th District: 1978, Robert R. Hartman, M.D.  
1515 A. W. Walnut, Jacksonville 62650
- 7th District: 1979, Alfred J. Kiessel, M.D.  
1800 E. Lake Shore Dr., Decatur 62521
- 8th District: 1979, James Laddlaw, M.D.  
104 W. Clark, Champaign 61820
- 9th District: 1978, Warren D. Tuttle, M.D.  
203 N. Vine St., Harrisburg 62946
- 10th District: 1978, Julian W. Buser, M.D.  
6600 W. Main, Bellevue 62223
- 11th District: 1977, Ross N. Hutchison, M.D.  
126 E. Ninth St., Gibson City 60936
- Trustee-At-Large: J. M. Ingalls, M.D.  
502 Shaw, Paris 61944
- Chairman of the Board: Robert T. Fox, M.D.  
2136 Robincrest, Glenview 60025

Microfilm copies of current as well as some back issues of the *Illinois Medical Journal* may be purchased from Xerox University Microfilm, 300 North Zeeb Road, Ann Arbor, Mich. 48106.

Contents of *IMJ* are listed in the *Current Contents/Clinical Practice*.

Published by the Illinois State Medical Society, 55 E. Monroe St., Chicago, Ill. 60603 (312-782-1654)  
Copyright, 1977. The Illinois State Medical Society.

Subscription \$8.00 per year, in advance, postage prepaid, for the United States, Cuba, Puerto Rico, Philippine Islands and Mexico. \$10.00 per year for all foreign countries included in the Universal Postal Union. Canada \$8.50. U.S. Single current copies available at \$1.00 (\$1.10 by mail), back issues \$1.50.

Second class postage paid at Chicago, Ill. When moving please notify Journal office of new address including old mailing label with notification, if possible. POSTMASTER: Send notice on form No. 3579 to Illinois State Medical Society, 55 E. Monroe St., Chicago, Ill. 60603.

Pharmaceutical advertising must be approved by the ISMS Publications Committee. Other advertising accepted after review by Publications Committee or Board of Trustees. All copy or plates must reach the Journal office by the fifteenth of the month preceding publication. Rates furnished upon request.

Original articles will be considered for publication with the understanding that they are contributed only to the *Illinois Medical Journal*. The ISMS denies responsibility for opinions and statements expressed by authors or in excerpts, other than editorial or allied views or statements which reflect the authoritative action of the ISMS or of reports on official actions, policies or positions. Views expressed by authors do not necessarily represent those of the Society; any connection with official policies is coincidental.

The *Illinois Medical Journal* is published by the Illinois State Medical Society as an educational and professional informational magazine and distributed as a benefit of membership in the Illinois State Medical Society. Its intent is to keep members current in medical knowledge and is a part of a continuing medical education program. Socioeconomic matters, affecting as they do a changing pattern in the proper delivery of medical care, are considered an inherent element in medical education.





## Illinois Medical Journal

APRIL, 1977

Vol. 151, No. 4

CONTENTS

---

238 Abstracts of Board Actions

---

### *Clinical Articles*

- 257 Nonfunctional Retroperitoneal Extra-Adrenal Paraganglioma  
*Dipankar Mukhopadhyay, M.B.B.S., F.R.C.P.(C) and  
Sidney M. Crain, B.S./Berwyn*
- 261 Teething in Infancy: A Part of Normal Development  
*Harvey Kravitz, M.D., Benjamin Emanuel, M.D.,  
Joseph Kasper, Ph.D. and Arthur Neyhus, Ph.D./Chicago*
- 267 Acute and Chronic Management of Children with Sick Cell Anemia  
and Cerebrovascular Occlusive Crisis  
*Ruth Andrea Seeler, M.D. and Joyce E. Royal, M.D./Chicago*
- 270 Physical Characteristics of Colon Polyps as a Determinant  
of Rational Management  
*Larry C. Gunn, M.D., F.A.C.S./Chicago*
- 274 Simultaneous Open Heart Surgery in Combination with other  
Surgical Procedures  
*Joseph C. Cleveland, M.D., F.A.C.S., F.C.C.P./Urbana*
- 

### *Special Articles*

- 286 The Panel for the Impaired Physician  
*Mariann McGuire*
- 293 Contraceptive Knowledge and Customs: A Study  
*Roger Bishop, M.D./Marion*
- 

### *Surgical Grand Rounds*

- 272 Case Report: Giant Diverticulum of Sigmoid  
*John M. Beal, M.D., Editor*
- 

### *President's Page*

- 279 What Do We Want?  
*Joseph H. Skom, M.D.*

(Contents continued on overleaf)

## Features

- 242 EKG of the Month
- 246 Obituaries
- 246 Clinics for Crippled Children
- 252 Viewbox
- 277 Doctor's News
- 292 Pulse of the Doctor's Wife
- 298 Membership Forum
- 300 New Pharmaceutical Specialties
- 302 ISMS Guide to Continuing Medical Education
- 304 Illinois Society, American Association of Medical Assistants
- 306 Physician Recruitment

## Staff

- Managing editor ..... Richard A. Ott
- Assistant editor ..... Mariann McGuire
- Executive administrator ..... Roger N. White

(Cover by Mike White/Omnicroft)

## PUBLICATIONS COMMITTEE

- Jacob E. Reisch, M.D., Springfield, *Chairman*
- Lawrence L. Hirsch, M.D., Chicago
- Alfred J. Kiessel, M.D., Decatur
- Warren D. Tuttle, M.D., Harrisburg
- Herman Wing, M.D., Chicago

- Contributor in Surgery: John M. Beal, M.D., Chicago
- Contributor in Maternal Death Studies: Robert Hartman, M.D., Jacksonville
- Contributor in Pediatric Perplexities: Ruth Andrea Seeler, M.D., Chicago
- Contributor in Radiology: Leon Love, M.D., Maywood
- Contributor in Cardiology: John R. Tobin, M.D., Maywood
- Contributor in Immunopathology: Richard J. Ablin, Ph.D., Chicago

## ILLINOIS STATE MEDICAL SOCIETY

### OFFICERS

- Joseph Skom, M.D., President  
707 Fairbanks Ct., Chicago 60611
- George Wilkins, M.D., President-Elect  
3165 Myrtle, Granite City 62040
- David S. Fox, M.D., 1st Vice-President  
826 E. 61st St., Chicago 60637
- Theodore Grevas, M.D., 2nd Vice-President  
2701 17th St., Rock Island 61201
- Jacob E. Reisch, M.D., Secretary-Treasurer  
1129 S. 2nd St., Springfield 62704

### HOUSE OF DELEGATES

- James A. McDonald, M.D., Speaker of the House  
515 Oakwood Dr., Geneva 60134
- Cyril C. Wiggishoff, M.D., Vice Speaker  
25 E. Washington, Suite 1805, Chicago 60602

### TRUSTEES

- 1st District: 1977, Joseph L. Bordenave, M.D.  
415 S. Second St., Geneva 60134
- 1A District: 1977, P. John Seward, M.D.  
2400 N. Rockton, Rockford 61101
- 2nd District: 1977, Allan L. Goslin, M.D.  
712 N. Bloomington, Streator 61364
- 3rd District: 1979, Alfred Clementi, M.D.  
675 W. Central Rd., Arlington Heights 60005
- 3rd District: 1977, Alfred J. Faber, M.D.  
2100 Swainwood Dr., Glenview 60025
- 3rd District: 1979, Robert T. Fox, M.D.  
2136 Robin Crest, Glenview 60025
- 3rd District: 1978, Henrietta Herbolzheimer, M.D.  
5528 S. Hyde Park Blvd., Apt. 1202, Chicago 60637
- 3rd District: 1978, Lawrence L. Hirsch, M.D.  
2434 Grace, Chicago 60618
- 3rd District: 1978, Eugene T. Hoban, M.D.  
6429 North Ave., Oak Park 60302
- 3rd District: 1977, William M. Lees, M.D.  
6518 North Nokomis, Lincolnwood 60066
- 3rd District: 1977, Joseph C. Sherrick, M.D.  
303 E. Superior, Chicago 60611
- 3rd District: 1977, Philip G. Thomsen, M.D.  
13826 Lincoln Ave., Dolton 60419
- 3rd District: 1979, Herman Wing, M.D.  
400 E. Randolph, Chicago 60601
- 4th District: 1979, Fred Z. White, M.D.  
723 N. 2nd St., Chillumcoke 61523
- 5th District: 1979, Paul F. Mahon, M.D.  
326 N. 7th St., Springfield 62702
- 6th District: 1978, Robert R. Hartman, M.D.  
1515 A. W. Walnut, Jacksonville 62650
- 7th District: 1979, Alfred J. Kiessel, M.D.  
1800 E. Lake Shore Dr., Decatur 62521
- 7th District: 1979, James Laidlaw, M.D.  
104 W. Clark, Champaign 61820
- 9th District: 1978, Warren D. Tuttle, M.D.  
203 N. Vine St., Harrisburg 62946
- 10th District: 1978, Julian W. Buser, M.D.  
6600 W. Main, Belleville 62223
- 11th District: 1977, Ross N. Hutchison, M.D.  
126 E. Ninth St., Gibson City 60936
- Trustee-At-Large: J. M. Ingalls, M.D.  
502 Shaw, Paris 61944
- Chairman of the Board: Robert T. Fox, M.D.  
2136 Robincrest, Glenview 60025

Microfilm copies of current as well as some back issues of the *Illinois Medical Journal* may be purchased from Xerox University Microfilm, 300 North Zeeb Road, Ann Arbor, Mich. 48106.

Contents of *IMJ* are listed in the *Current Contents/Clinical Practice*.

Published by the Illinois State Medical Society, 55 E. Monroe St., Chicago, Ill. 60603 (312-782-1654) Copyright, 1977. The Illinois State Medical Society.

Subscription \$8.00 per year, in advance, postage prepaid, for the United States, Cuba, Puerto Rico, Philippine Islands and Mexico. \$10.00 per year for all foreign countries included in the Universal Postal Union. Canada \$8.50, U.S. Single current copies available at \$1.00 (\$1.10 by mail), back issues \$1.50.

Second class postage paid at Chicago, Ill. When moving please notify Journal office of new address including old mailing label with notification, if possible. POSTMASTER: Send notice on form No. 3579 to Illinois State Medical Society, 55 E. Monroe St., Chicago, Ill. 60603.

Pharmaceutical advertising must be approved by the ISMS Publications Committee. Other advertising accepted after review by Publications Committee or Board of Trustees. All copy or plates must reach the Journal office by the fifteenth of the month preceding publication. Rates furnished upon request.

Original articles will be considered for publication with the understanding that they are contributed only to the *Illinois Medical Journal*. The ISMS denies responsibility for opinions and statements expressed by authors or in excerpts, other than editorial or allied views or statements which reflect the authoritative action of the ISMS or of reports on official actions, policies or positions. Views expressed by authors do not necessarily represent those of the Society; any connection with official policies is coincidental.

The *Illinois Medical Journal* is published by the Illinois State Medical Society as an educational and professional informational magazine and distributed as a benefit of membership in the Illinois State Medical Society. Its intent is to keep members current in medical knowledge and is a part of a continuing medical education program. Socioeconomic matters, affecting as they do a changing pattern in the proper delivery of medical care, are considered an inherent element in medical education.







## Illinois Medical Journal

MAY, 1977

Vol. 151, No. 5

CONTENTS

---

### *Clinical Articles*

- 368      Hyperparathyroidism In A Patient With Thyroid Hemiagenesis  
             Robert J. Maganini, M.D., F.A.C.S., and K. Narendran, M.D.,  
             Hinsdale and Hines
- 382      Diagnostic Uses for Ultrasonography  
             Robert P. Smith, M.D./Urbana
- 384      Correct Positioning of the Endotracheal Tube  
             Robert H. Libman, M.D./Chicago
- 387      The Increasing Abuse of Phencyclidine  
             Craig V. Showalter, M.D. and William E. Thornton, M.D./Chicago
- 

### *Special Articles*

- 355      Medical Care Evaluation Studies Under the Hospital Admission and  
             Surveillance Program  
             Fred Z. White, M.D., M.A./Chillicothe
- 360      Night Calls in Family Practice  
             Brian W. McGuinness, M.D./Merseyside, England
- 

### *Surgical Grand Rounds*

- 375      Case Report: Coarctation of the Aorta  
             John M. Beal, M.D., Editor
- 

### *Pediatric Perplexities*

- 371      Congenital Syphilis With Unusual Clinical Presentations:  
             Value of Bone Roentgenograms in Diagnosis.  
             Ruth Andrea Seeler, M.D., Editor
- 

### *President's Page*

- 365      Who Are "Those Guys"?  
             George T. Wilkins, Jr., M.D.

(Contents continued on overleaf)

## Features

- 321 EKG of the Month
- 324 Obituaries
- 328 Viewbox
- 337 Clinics for Crippled Children
- 338 Illinois Society, American Association of Medical Assistants
- 340 New Pharmaceutical Specialties
- 342 Membership Forum
- 350 Physician Recruitment
- 363 Doctor's News
- 366 Guest Editorial
- 390 Pulse of the Doctor's Wife
- 392 ISMS Guide to Continuing Medical Education

## Staff

Managing editor ..... Richard A. Ott  
 Assistant editor ..... Mariann E. McGuire  
 Executive administrator ..... Roger N. White

(Cover Photo by Ed Stecki)

## PUBLICATIONS COMMITTEE

Jacob E. Reisch, M.D., Springfield, *Chairman*  
 Lawrence L. Hirsch, M.D., Chicago  
 Alfred J. Kiesel, M.D., Decatur  
 Warren D. Tuttle, M.D., Harrisburg  
 Herman Wing, M.D., Chicago

Contributor in Surgery: John M. Beal, M.D., Chicago

Contributor in Maternal Death Studies:

Robert Hartman, M.D., Jacksonville

Contributor in Pediatric Perplexities: Ruth Andrea Seeler, M.D., Chicago

Contributor in Radiology: Leon Love, M.D., Maywood

Contributor in Cardiology: John R. Tobin, M.D., Maywood

Contributor in Immunopathology: Richard J. Ablin, Ph.D., Chicago

## ILLINOIS STATE MEDICAL SOCIETY

### OFFICERS

George T. Wilkins, M.D., President  
 3165 Myrtle, Granite City 62040  
 David S. Fox, M.D., President-Elect  
 826 E. 61st St., Chicago 60637  
 Theodore Grevas, M.D., 1st Vice-President  
 2701 17th St., Rock Island 61201  
 William M. Lees, M.D., 2nd Vice-President  
 6518 North Nokomis, Lincolnwood 60046  
 Eugene P. Johnson, M.D., Secretary-Treasurer  
 P.O. Box 68, Casey 62420

### HOUSE OF DELEGATES

Cyril C. Wiggishoff, M.D., Speaker  
 25 E. Washington, Suite 1805, Chicago 60602  
 Robert P. Johnson, M.D., Vice Speaker  
 108 Maple Grove, Springfield 62707

### TRUSTEES

1st District: 1980, Joseph L. Bordenave, M.D.  
 415 S. Second St., Geneva 60134  
 2nd District: 1980, Allan L. Goslin, M.D.  
 712 N. Bloomington, Streator 61364  
 3rd District: 1980, Herschel Browns, M.D.  
 4600 N. Ravenswood, Chicago 60640  
 3rd District: 1979, Alfred Clementi, M.D.  
 675 W. Central Rd., Arlington Heights 60005  
 3rd District: 1980, Audley F. Connor, Jr., M.D.  
 3233 King Dr., Chicago 60616  
 3rd District: 1980, Alfred J. Faber, M.D.  
 3851 Mission Hills Road, Northbrook 60062  
 3rd District: 1979, Robert T. Fox, M.D.  
 2136 Robin Crest, Glenview 60025  
 3rd District: 1978, Henrietta Herbolzheimer, M.D.  
 5528 S. Hyde Park Blvd., Apt. 1202, Chicago 60637  
 3rd District: 1978, Lawrence L. Hirsch, M.D.  
 2434 Grace, Chicago 60618  
 3rd District: 1978, Eugene T. Hoban, M.D.  
 6429 North Ave., Oak Park 60302  
 3rd District: 1980, Joseph C. Sherrick, M.D.  
 303 E. Superior, Chicago 60611  
 3rd District: 1979, Herman Wing, M.D.  
 155 N. Narbor Dr., Chicago 60601  
 4th District: 1979, Fred Z. White, M.D.  
 723 N. 2nd St., Chillicothe 61523  
 5th District: 1979, Paul F. Mahon, M.D.  
 326 N. 7th St., Springfield 62702  
 6th District: 1978, Robert R. Hartman, M.D.  
 1515 A. W. Walnut, Jacksonville 62650  
 7th District: 1979, Alfred J. Kiesel, M.D.  
 1 Powers Lane Pl., Decatur 62521  
 8th District: 1979, James Laidlaw, M.D.  
 104 W. Clark, Champaign 61820  
 9th District: 1978, Warren D. Tuttle, M.D.  
 203 N. Vine St., Harrisburg 62946  
 10th District: 1978, Julian W. Buser, M.D.  
 6600 W. Main, Belleville 62223  
 11th District: 1980, Kenneth A. Hurst, M.D.  
 52 Bunting Lane, Naperville 60450  
 12th District: 1980, P. John Seward, M.D.  
 2400 N. Rockton, Rockford 61101  
 Trustee-At-Large: Joseph Skom, M.D.  
 707 Fairbanks Ct., Chicago 60611  
 Chairman of the Board: Robert T. Fox, M.D.  
 2136 Robincrest, Glenview 60025

Microfilm copies of current as well as some back issues of the *Illinois Medical Journal* may be purchased from Xerox University Microfilm, 300 North Zeeb Road, Ann Arbor, Mich. 48106.

Contents of *IMJ* are listed in the *Current Contents/Clinical Practice*.

Published by the Illinois State Medical Society, 55 E. Monroe St., Chicago, Ill. 60603 (312-782-1654)

Copyright, 1977. The Illinois State Medical Society.

Subscription \$8.00 per year, in advance, postage prepaid, for the United States, Cuba, Puerto Rico, Philippine Islands and Mexico. \$10.00 per year for all foreign countries included in the Universal Postal Union. Canada \$8.50. U.S. Single current copies available at \$1.00 (\$1.10 by mail), back issues \$1.50.

Second class postage paid at Chicago, Ill. When moving please notify Journal office of new address including old mailing label with notification, if possible. POSTMASTER: Send notice on form No. 3579 to Illinois State Medical Society, 55 E. Monroe St., Chicago, Ill. 60603.

Pharmaceutical advertising must be approved by the ISMS Publications Committee. Other advertising accepted after review by Publications Committee or Board of Trustees. All copy or plates must reach the Journal office by the fifteenth of the month preceding publication. Rates furnished upon request.

Original articles will be considered for publication with the understanding that they are contributed only to the *Illinois Medical Journal*. The ISMS denies responsibility for opinions and statements expressed by authors or in excerpts, other than editorial or allied views or statements which reflect the authoritative action of the ISMS or of reports on official actions, policies or positions. Views expressed by authors do not necessarily represent those of the Society; any connection with official policies is coincidental.

The *Illinois Medical Journal* is published by the Illinois State Medical Society as an educational and professional informational magazine and distributed as a benefit of membership in the Illinois State Medical Society. Its intent is to keep members current in medical knowledge and is a part of a continuing medical education program. Socioeconomic matters, affecting as they do a changing pattern in the proper delivery of medical care, are considered an inherent element in medical education.





## Illinois Medical Journal

JUNE, 1977

Vol. 151, No. 6

CONTENTS

- 
- |     |  |
|-----|--|
| 405 | Abstracts of Board of Trustees Actions |
| 493 | Accumulative Index, Volume 151         |
- 

### *Convention Summary*

- |     |  |
|-----|--|
| 452 | 1977-78 Officers and Board of Trustees |
| 453 | Highlights of 1977 Annual Meeting      |
| 461 | Summary of House of Delegates Actions  |
| 467 | Actions on Resolutions                 |
- 

### *Clinical Articles*

- |     |  |
|-----|--|
| 433 | Ultrastructure of Skeletal Muscle in a Case of Malignant Hyperpyrexia<br><i>Jose J. Navas, M.D.</i>  |
| 437 | Anomalous Origin of the Left Coronary Artery from the<br>Main Pulmonary Artery<br><i>B. Agarwala, M.D., R. Agarwala, M.D.,<br/>W. Thomas, Jr., M.D. and S. Bharati, M.D.</i> |
- 

### *Pediatric Perplexities*

- |     |   |
|-----|---|
| 418 | Vitamin D Poisoning from Ingestion of Concentrated Vitamin D<br>Used to Fortify Milk<br><i>Ruth A. Secler, M.D., Editor</i> |
|-----|---|
- 

### *Surgical Grand Rounds*

- |     |   |
|-----|---|
| 443 | Foreign Bodies in the Gastrointestinal Tract<br><i>John M. Beal, M.D., Editor</i> |
|-----|---|
- 

### *President's Page*

- |     |   |
|-----|---|
| 448 | Responsibility Before the Vote<br><i>George T. Wilkins, Jr., M.D.</i> |
|-----|---|
- 

(Contents continued on overleaf)

## Features

- 411 Editorial
- 423 Clinics for Crippled Children
- 424 EKG of the Month
- 430 New Pharmaceutical Specialties
- 449 Doctor's News
- 473 Pulse of the Doctor's Wife
- 482 Illinois Society, American Association  
of Medical Assistants
- 487 Obituaries
- 488 Physician Recruitment
- 490 ISMS Guide to Continuing Medical  
Education

## Staff

- Managing editor ..... Richard A. Ott  
 Assistant editor ..... Mariann E. McGuire  
 Executive administrator ..... Roger N. White

## PUBLICATIONS COMMITTEE

- Lawrence L. Hirsch, M.D., Chicago, *Chairman*  
 Kenneth A. Hurst, M.D., Naperville  
 Robert P. Johnson, M.D., Springfield  
 Alfred J. Kiessel, M.D., Decatur  
 Herman Wing, M.D., Chicago

Contributor in Surgery: John M. Beal, M.D., Chicago  
 Contributor in Maternal Death Studies:  
 Robert Hartman, M.D., Jacksonville

- Contributor in Pediatric Perplexities: Ruth Andrea Seeler, M.D., Chicago  
 Contributor in Radiology: Leon Love, M.D., Maywood  
 Contributor in Cardiology: John R. Tobin, M.D., Maywood  
 Contributor in Immunopathology: Richard J. Ablin, Ph.D., Chicago

## ILLINOIS STATE MEDICAL SOCIETY

### OFFICERS

- George T. Wilkins, M.D., President  
 3165 Myrtle, Granite City 62040  
 David S. Fox, M.D., President-Elect  
 826 E. 61st St., Chicago 60637  
 Theodore Grevas, M.D., 1st Vice-President  
 2701 17th St., Rock Island 61201  
 William M. Lees, M.D., 2nd Vice-President  
 6518 North Nokomis, Lincolnwood 60064  
 Eugene P. Johnson, M.D., Secretary-Treasurer  
 P.O. Box 68, Casey 62420

### HOUSE OF DELEGATES

- Cyril C. Wiggishoff, M.D., Speaker  
 25 E. Washington, Suite 1805, Chicago 60602  
 Robert P. Johnson, M.D., Vice Speaker  
 108 Maple Grove, Springfield 62707

### TRUSTEES

- 1st District: 1980, Joseph L. Bordenave, M.D.  
 415 S. Second St., Geneva 60134  
 2nd District: 1980, Allan L. Godin, M.D.  
 712 N. Bloomington, Streator 61364  
 3rd District: 1980, Herschel Browns, M.D.  
 4600 N. Ravenswood, Chicago 60640  
 3rd District: 1979, Alfred Clementi, M.D.  
 675 W. Central Rd., Arlington Heights 60005  
 3rd District: 1980, Audley F. Connor, Jr., M.D.  
 3233 King Dr., Chicago 60616  
 3rd District: 1980, Alfred J. Faber, M.D.  
 3851 Mission Hills Road, Northbrook 60062  
 3rd District: 1979, Robert T. Fox, M.D.  
 2136 Robincrest, Glenview 60025  
 3rd District: 1978, Henrietta Herbolzheimer, M.D.  
 5528 S. Hyde Park Blvd., Apt. 1202, Chicago 60637  
 3rd District: 1978, Lawrence L. Hirsch, M.D.  
 2434 Grace, Chicago 60618  
 3rd District: 1978, Eugene T. Hohan, M.D.  
 6429 North Ave., Oak Park 60302  
 3rd District: 1980, Joseph C. Sherrick, M.D.  
 303 E. Superior, Chicago 60611  
 3rd District: 1979, Herman Wing, M.D.  
 155 N. Harbor Dr., Chicago 60601  
 4th District: 1979, Fred Z. White, M.D.  
 723 N. 2nd St., Chillumbe 61523  
 5th District: 1979, Paul F. Mahon, M.D.  
 326 N. 7th St., Springfield 62702  
 6th District: 1978, Robert R. Hartman, M.D.  
 1515 A. W. Walnut, Jacksonville 62650  
 7th District: 1979, Alfred J. Kiessel, M.D.  
 1 Powers Lane Pl., Decatur 62521  
 8th District: 1979, James Laidlaw, M.D.  
 104 W. Clark, Champaign 61820  
 9th District: 1978, Warren D. Tuttle, M.D.  
 203 N. Vine St., Harrisburg 62946  
 10th District: 1978, Julian W. Buser, M.D.  
 6600 W. Main, Belleville 62223  
 11th District: 1980, Kenneth A. Hurst, M.D.  
 52 Bunting Lane, Naperville 60450  
 12th District: 1980, P. John Seward, M.D.  
 2400 N. Rockton, Rockford 61101  
 Trustee-At-Large: Joseph Skom, M.D.  
 707 Fairbanks Ct., Chicago 60611  
 Chairman of the Board: Robert T. Fox, M.D.  
 2136 Robincrest, Glenview 60025

Microfilm copies of current as well as some back issues of the *Illinois Medical Journal* may be purchased from Xerox University Microfilm, 300 North Zeeb Road, Ann Arbor, Mich. 48106.

Contents of *IMJ* are listed in the *Current Contents/Clinical Practice*.

Published by the Illinois State Medical Society, 55 E. Monroe St., Chicago, Ill. 60603 (312-782-1654)  
 Copyright, 1977, The Illinois State Medical Society.

Subscription \$8.00 per year, in advance, postage prepaid, for the United States, Cuba, Puerto Rico, Philippine Islands and Mexico. \$10.00 per year for all foreign countries included in the Universal Postal Union. Canada \$8.50. U.S. Single current copies available at \$1.00 (\$1.10 by mail), back issues \$1.50.

Second class postage paid at Chicago, Ill. When moving please notify Journal office of new address including old mailing label with notification, if possible. POSTMASTER: Send notice on form No. 3579 to Illinois State Medical Society, 55 E. Monroe St., Chicago, Ill. 60603.

Pharmaceutical advertising must be approved by the ISMS Publications Committee. Other advertising accepted after review by Publications Committee or Board of Trustees. All copy or plates must reach the Journal office by the fifth day of the month preceding publication. Rates furnished upon request.

Original articles will be considered for publication with the understanding that they are contributed only to the *Illinois Medical Journal*. The ISMS denies responsibility for opinions and statements expressed by authors or in excerpts, other than editorial or allied views or statements which reflect the authoritative action of the ISMS or of reports on official actions, policies or positions. Views expressed by authors do not necessarily represent those of the Society; any connection with official policies is coincidental.

The *Illinois Medical Journal* is published by the Illinois State Medical Society as an educational and professional informational magazine and distributed as a benefit of membership in the Illinois State Medical Society. Its intent is to keep members current in medical knowledge and is a part of a continuing medical education program. Socioeconomic matters, affecting as they do a changing pattern in the proper delivery of medical care, are considered an inherent element in medical education.





Blue Cross®  
Blue Shield®



# REPORT

## FOR *Illinois Physicians*

### Blue Shield Benefits Broadened for Chrysler Employees

Effective January 1, 1977, new benefit adjustments have been made to the health care program of Chrysler Corporation employees. The groups in Illinois participating in the program are: #79200, #79201, #79246 and #79400.

Blue Shield benefit improvements include:

**CHEMOTHERAPY:** Services of a physician are covered for the administration of chemotherapy drugs in the patient's home. Services previously were payable only on a hospital inpatient basis, hospital outpatient basis or in a physician's office.

**DURABLE MEDICAL EQUIPMENT:** Benefits will be provided on a Usual and Customary charge basis for the rental or purchase of durable medical equipment from any provider except a hospital or convalescent and long term illness care facility, when the equipment meets the current criteria for durable medical equipment, is prescribed by a licensed physician, and is listed in the categories of equipment covered by Part B Medicare as of October 1, 1975.

• When a physician's recertification is not submitted, benefits for the rental of durable medical equipment will cease as of the original duration of need date or 30 days after the patient's date of death.

**PROSTHETIC APPLIANCES:** Benefits include external orthotic and prosthetic appliances covered under the program obtained from facilities having conditional accreditation from ABC (American Board for Certification in Orthotics and Prosthetics).

• Ostomy sets and accessories, catheterization equipment and urinary sets are covered under the new benefit.

• The list of appliances which may be purchased from facilities not accredited by ABC has been expanded to also include such items as: artificial ears, noses and larynxes; and external breast prostheses.

• Benefits are payable for prescription lenses prescribed by an optometrist.

**OUTPATIENT PSYCHIATRIC CARE:** The combined Blue Cross and Blue Shield benefit payment of \$800 per member, per calendar year for psychiatric outpatient care is increased to \$1000.

**SUBSTANCE ABUSE PROGRAM:** Coverage is extended to include retirees, surviving spouses and their eligible dependents for treatment in approved Blue Cross residential substance abuse facilities.

**PRESCRIPTION DRUG PROGRAM:** The \$2.00 copayment per prescription order and refill is increased to \$3.00.

• Specific maintenance legend drugs will be categorized for those which will be dispensed in quantities of 100 or 200-unit doses, if greater than a 34-day supply.

(The list contains all the maintenance drugs covered under the program which may be dispensed in maximum quantities of a 34-day supply or 100 unit doses; or a 34-day supply or 200 unit doses, whichever is greater, regardless of brand name.)

**MEDICAL EMERGENCY:** Coverage for treatment of a medical emergency is a new benefit. The following criteria will enable uniform delivery between Blue Cross-Blue Shield:

• The medical emergency benefit will be administered on the basis of signs or symptoms shown by the patient as verified by the physician *at the time of treatment and not on the basis of final diagnosis.*

• A medical emergency will not be considered to exist if medical treatment is not secured within 72 hours after the onset of the condition.

• The following criteria has been developed for utilization by the Plan's medical consultants in determining the existence of a medical emergency condition and whether benefits would be payable when the provisional or working diagnosis (as determined by the attending physician) is not included in the Medical Emergency Diagnoses List:

(1) The condition is permanent; health threatening or disabling;

(2) Medical attention and treatment is required;

(3) Failure to render care and/or treatment could reasonably result in deterioration to the point of placing the patient's permanent health in jeopardy and/or causing significant impairment to bodily functions;

(4) Signs or symptoms displayed by the patient (as verified by the physician) at the time of treatment;

(5) Prompt care must be secured within 72 hours after the onset of the condition;

(6) Acute symptoms must occur suddenly and unexpectedly.

**BRAIN SCAN TESTS:** Computer Transaxial Tomography (CAT) is a covered procedure for brain scans only when provided on equipment approved by a recognized health planning agency.

**GRADED CARDIAC EXERCISE TEST:** Benefits for this procedure will be provided in local Plan areas when the Control Plan determines that adequate medical necessity criteria has been adopted. This criteria includes the requirement that the patient shows symptoms of cardiovascular disease or abnormal physical, laboratory or other findings which suggest the possibility of cardiovascular disease.

## ASK BLUE SHIELD

### . . . ABOUT MEDICARE

## Medicare Guidelines for Payment of Psychiatric Services

Certain guidelines determine Medicare payments allowed for psychiatric inpatient care and for outpatient services in a physician's office, patient's home, extended care facility or similarly approved Medicare facility.

Inpatient psychiatric services are reimbursable at 80% of the reasonable charge, subject to the Part B \$60.00 deductible. These services *are not* subject to limitations placed on outpatient services and are processed the same way as other medical benefits.

Below is a listing of inpatient psychiatric services which correspond to the codes used by Health Care Service Corporation (Part B Medicare carrier for Cook County):

(1) Initial hospital visit, including interview, history and physical examination (2) routine hospital visit (3) in-hospital psychiatric care per week (to be used only when the physician bills on a weekly basis. The fee includes EST, IST, psychotherapy and/or interview) (4) psychiatric consultation including history, physical and interview (5) electroshock therapy, per treatment (including polarity treatment) (6) insulin shock therapy, per treatment (7) drug induced convulsive therapy, per treatment (8) psychotherapeutic session, 30 minutes or less (9) psychotherapeutic session, over 30 minutes, up to and including 60 minutes (10) psychotherapeutic session over 60 minutes (11) group session, per person (12) family counseling or interview (13) psychological testing, per testing session.

When billing for any of the above services, it would be helpful to the Medicare carrier to use the same or very similar terminology as that given above.

If a physician bills for psychiatric care on a weekly basis, this should be so stated on the claim.

It is important that all psychotherapeutic sessions show the length of time of the session.

### Office and Outpatient Care

Office and outpatient psychiatric services are subject to certain limitations. Regardless of the actual expenses incurred for physicians' services in connection with the diagnosis and treatment of mental, psychoneurotic or personality disorders of patients who are not inpatients of hospitals, the amount of such expenses that can be counted in a calendar year is limited to the lesser of \$312.50 or 62.5% of the actual expenses.

Since \$312.50 is 62.5% of \$500.00, any amount in excess of \$500.00 would not be considered in computing reimbursement. These services are also subject to the \$60.00 deductible and payment at 80% of the reasonable charge. Therefore, the maximum possible payment for services would be 80% of \$312.50 or \$250.00 if the \$60.00 deductible had been met. If none of the deductible had been met, the maximum possible payment would be \$202.00. To compute the benefit payable: (1) Consider all expenses incurred up to a maximum of \$500.00 (2) Multiply

by 62.5% (3) Subtract any portion of an unsatisfied deductible (4) Multiply by 80%.

Below is a listing of outpatient psychiatric services which correspond to the codes used by HCSC:

(1) Initial psychiatric interview, diagnostic history and physical examination (2) psychotherapeutic session, 30 minutes or less (3) psychotherapeutic session over 30 minutes, to and including 60 minutes (4) psychotherapeutic session over 60 minutes; (5) group session, per person (6) family interview or counseling (7) electroshock therapy, per treatment (8) insulin shock therapy, per treatment (9) drug induced convulsive therapy, per treatment (10) psychological testing, per testing session.

When billing for psychotherapeutic session, always include the length of time spent per session.

The psychiatric services limitation applies to outpatient services *regardless of the specialty or the treating physician and regardless of the type of treatment*, as long as the services are in connection with the diagnosis and/or treatment of mental, psychoneurotic or personality disorders.

## SSA Changes In Laboratory Certifications

Notice was received from the Bureau of Health Insurance, Social Security Administration, of the following changes in participation or certification status of laboratories in the Medicare program.

### Approved For Participation In Medicare Program:

Amcor Portable X-ray Service, 2320 North Damen Avenue, Chicago, Illinois 60647 (Provider Number 14-9812) has been approved for participation in the Medicare program as a supplier of portable X-ray services. Effective date of coverage is July 13, 1976.

Harvey Medical Laboratory, 15320 South Center, Harvey, Illinois 60426 (Provider Number 14-8319) has been approved for participation in the Medicare program. The effective date is July 9, 1976. The laboratory is approved to perform the following tests and procedures: Bacteriology, Mycology, Parasitology, Serology, Chemistry, Hematology, Blood Group and Rh Typing and Diagnostic Cytology.

### Cook County Health Department Moves To New Location

The Cook County Health Department is now located at 1500 South Maybrook Drive, Maywood, Illinois 60153. Physicians and other providers are requested to change their records accordingly. The Provider Number is 14-7024.

# Medical Data-Plan®

**We're not offering you  
just a computerized  
billing system.  
We're offering you a way  
to plan the future  
of your practice.**

Medical Data-Plan is a computerized system for getting bills out, processing insurance forms, speeding up cash flow and improving collections.

It also gives you the information you need to plan the future of your practice . . . 3 years, 5 years, 10 years from now.

Based on a steady flow of accurate, timely computer reports, your business manager can make sound recommendations on personnel, equipment, materials, facilities and more. Medical Data-Plan can show you what your practice has been doing—and what it should be doing.

Clip this coupon to receive information or to arrange an appointment with a Data-Plan representative.



**Data-Plan**

Medical Data-Plan  
Box 7947, Madison, Wisconsin 53707

Name \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_

State \_\_\_\_\_ Zip \_\_\_\_\_

Check one or both boxes below:

☐ Please mail me more information about Medical Data-Plan.

☐ Please have a representative contact me. My phone number is: \_\_\_\_\_

(area code)

(number)

4-1



# Editorials



## *Good Luck, Dr. Ted*

Fortunate, indeed, is the medical newspaper or magazine with an editor totally dedicated to the profession, to journalistic excellence, and to the public.

The name of Theodore R. Van Dellen, M.D., Dr. Ted to many of those who know him, will no longer appear on the masthead of the *Illinois Medical Journal*. Dr. Ted is retiring.

Since the establishment of this journal in 1899, a small but illustrious group of men have served as editors. All have left their mark and helped to develop the *IMJ* into a valuable communication tool, providing access to medical education and descriptions of procedures, to help the members care for patients. The editors included Drs. Kreider, Pence, Olds, Whalen and Camp.

Taking his place in this Hall of Fame is Dr. Van Dellen.

To recount all of his accomplishments, his affiliations, or his activities would be a difficult task, too much for the limited space available on this page, which he wrote for some 20 years. Suffice it to say that he was nationally known for his syndicated column, "How to Keep Well," was a medical educator, and served his profession and his society well. An internist, he also continued a limited practice so as never to cease being a clinician.

From his many friends in ISMS, and especially from the staff, a hearty "Good Luck" is extended to Dr. Ted, and his wife, Janet, as they enjoy their well-earned free time in the sunny clime of Florida.

R. Ott

# DYAZIDE®

Trademark

Each capsule contains 50 mg. of Dyrenium® (triamterene, SK&F Co.) and 25 mg. of hydrochlorothiazide.

## MAKES SENSE FOR LONG-TERM CONTROL OF HYPERTENSION\*



Before prescribing, see complete prescribing information in SK&F Co. literature or PDR. A brief summary follows:

### WARNING

This fixed combination drug is not indicated for initial therapy of edema or hypertension. Edema or hypertension requires therapy titrated to the individual patient. If the fixed combination represents the dosage so determined, its use may be more convenient in patient management. The treatment of hypertension and edema is not static, but must be reevaluated as conditions in each patient warrant.

**Indications:** When the fixed combination represents the dosage determined by titration: Adjunctive therapy in edema associated with congestive heart failure, hepatic cirrhosis, the nephrotic syndrome. Corticosteroid and estrogen-induced edema, idiopathic edema; hypertension, when the potassium-sparing action of its 'Dyrenium' component is warranted.

**Contraindications:** Further use in progressive renal or hepatic dysfunction; hyperkalemia. Pre-existing elevated serum potassium. Hypersensitivity to either component or other sulfonamide-derived drugs. Routine use of diuretics in otherwise healthy pregnancy.

**Warnings:** Do not use potassium supplements, dietary or otherwise, unless hypokalemia develops or dietary intake of potassium is markedly impaired; if supplementary potassium is needed, potassium tablets should not be used. Hyperkalemia can occur, and has been associated with

cardiac irregularities. It is more likely in severely ill patients with urine volume less than one liter/day, the elderly or diabetics, with suspected or confirmed renal insufficiency. Periodic determinations of serum K<sup>+</sup> should be made. If hyperkalemia develops, substitute a thiazide alone, restrict K<sup>+</sup> intake. The presence of a widened QRS complex or arrhythmia in association with hyperkalemia requires prompt additional therapy. Thiazides are reported to cross the placental barrier and appear in breast milk; fetal or neonatal hyperbilirubinemia, thrombocytopenia, altered carbohydrate metabolism and other adverse reactions that have occurred in the adult may result. When used in pregnancy or in women who might bear children, weigh potential benefits against possible hazards to fetus. Adequate information on use in children is not available.

**Precautions:** Do periodic serum electrolyte determinations (particularly important in patients vomiting excessively or receiving parenteral fluids). Periodic BUN and serum creatinine determinations should be made, especially in the elderly, diabetics, or those with suspected or confirmed renal insufficiency. Watch for signs of impending coma in severe liver disease. If spironolactone is used concomitantly, determine serum K<sup>+</sup> frequently; both can cause K<sup>+</sup> retention and elevated serum K<sup>+</sup>. Two deaths have been reported with such concomitant therapy (in one, recommended dosage was exceeded, in the other serum electrolytes were not properly monitored). Observe regularly for possible blood dyscrasias, liver damage, other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving Dyrenium® (triamterene, SK&F Co.), and

leukopenia, thrombocytopenia, agranulocytosis, and aplastic anemia have been reported with thiazides. Do periodic blood studies in cirrhotics to check for nondrug-related variations in blood pictures, and in patients with folic acid depletion, since 'Dyrenium' may contribute to appearance of megaloblastosis. Antihypertensive effect may be enhanced in post-sympathectomy patients. Use cautiously in surgical patients. The following may occur: transient elevated BUN or creatinine or both, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), hyperuricemia and gout, digitalis intoxication (in hypokalemia), decreasing alkali reserve with possible metabolic acidosis. 'Dyazide' interferes with fluorescent measurement of quinidine.

**Adverse Reactions:** Muscle cramps, weakness, dizziness, headache, dry mouth; anaphylaxis, rash, urticaria, photosensitivity, purpura, other dermatological conditions; nausea and vomiting, diarrhea, constipation, other gastrointestinal disturbances. Necrotizing vasculitis, paresthesias, icterus, pancreatitis, xanthopsia and, rarely, allergic pneumonitis have occurred with thiazides alone.

**Supplied:** Bottles of 100 and 1000 capsules; Single Unit Packages of 100 (intended for institutional use only).

**SK&F CO.,** Carolina, P.R. 00630

Subsidiary of SmithKline Corporation

## TRIAMTERENE CONSERVES POTASSIUM WHILE HYDROCHLOROTHIAZIDE LOWERS BLOOD PRESSURE

# *Abstracts of Board Actions*

November 5-7, 1976

Peoria

*These abstracts are published so that members of the Illinois State Medical Society may keep advised of the actions of the Board of Trustees. It covers only major actions and is not intended as a detailed report. Full minutes of the meetings are available upon any member's request to the headquarters office of the ISMS.*

## **House of Delegates**

The 1977 annual meeting of the House of Delegates will be held April 24-27 at the Holiday Inn Mart Plaza in Chicago. Deadline for resolutions to be printed in the Illinois Medical Journal will be February 20; final deadline for resolutions will be March 27. Illinois specialty societies will be invited to sponsor programs during the annual meeting at times when the House of Delegates is not in session. The 1977 interim session may be held in Rockford.

## **Guidelines for Treatment of Rape Victims**

ISMS will urge the Illinois Department of Public Health to: (1) Reconvene the Rape Law Advisory Committee to review the Guidelines for Treatment of Sexual Assault Victims and delete several objectionable features; (2) Invite an attorney to participate in the review to identify medical-legal problems involved in the guidelines; and (3) Include a section on transmission of evidence to assist rural hospitals. The ISMS Committee on Emergency and Disaster Care will develop recommendations for changes in the guidelines which the society's representatives can present to the Rape Law Advisory Committee.

## **ISMS Comments on HR 6222**

Upon recommendation of its National Legislation Committee, ISMS has urged AMA not to reintroduce its national health insurance bill until: (1) Medicare and Medicaid reforms have been implemented; and (2) Catastrophic coverage, using private insurance carriers, has been developed.

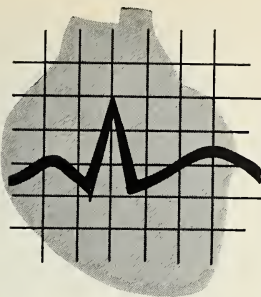
## **Decline Defense Fund Contribution**

Because federal laws prohibit ISMS dues money or assessments from inuring to any one physician, the Board declined an Illinois Physicians' Union request to contribute to the Committee for the Defense of Dr. Carell Hutchinson, who has had two separate lawsuits brought against him by a factoring company.

## **Peer Review on Fee Review**

Because opinions of Peer Review Committees are advisory only, the Board of Trustees believes that decisions involving fee review should rest solely with the local county medical society, with no avenue for appeal. The Council on Economics and Peer Review was directed to study the matter and draft a resolution to amend the bylaws to prohibit appeals on fee review cases. Until the House has had an opportunity to consider such a proposal, all fee review cases pending before the ISMS Review Appeals Committee will be held in abeyance.

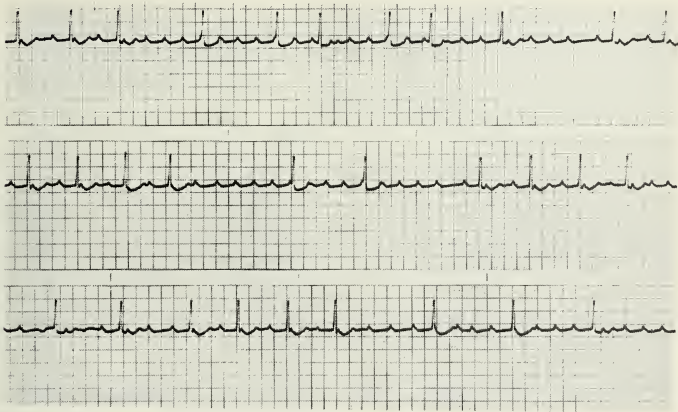
*(Continued on page 35)*



## ekg of the month

JOHN R. TOBIN, JR., M.S., M.D., RIMGAUDAS NEMICKAS, M.D.,  
PATRICK J. SCANLON, M.D., JOHN F. MORAN, M.S., M.D.,  
SARAH JOHNSON, M.D., and ROLF M. GUNNAR, M.S., M.D./  
Section of Cardiology, Department of Medicine,  
Loyola University Stritch School of Medicine

A fifty-six year old woman complained to her physician of intermittent light-headedness which seemed to be worsening. She had had open heart surgery and mitral valve replacement four years earlier for severe mitral regurgitation secondary to rheumatic heart disease. She had been well until these episodes of lightheadedness. The patient denied any syncopal episodes or other cardiovascular complaints and was taking no medication. Physical exam showed a blood pressure of 100/60, normal lungs, and an irregular, slow pulse. The ECG rhythm strip was taken.



### Questions:

**1. The ECG shows:**

- A. Atrial tachycardia.
- B. Atrial tachycardia with irregular atrial cycles.
- C. Advanced, severe, or high grade atrioventricular block.
- D. Evidence for concealed conduction.
- E. All of the above.

**2. The therapy here should include:**

- A. Rapid intravenous digoxin.
- B. 100 mg lidocaine bolus followed by a lidocaine drip.
- C. Procainamide 500 mg Q 6 hours.
- D. Quinidine 300 mg Q 6 hours.
- E. Demand pacemaker.

*(Answers on page 50)*



## Obituaries

\*Avery, Loren W., Chicago, died November 12, at the age of 82. Doctor Avery was a 1920 graduate of Rush Medical College.

\*Dolph, I. E., Chillicothe, died November 19, at the age of 73. Doctor Dolph was a 1932 graduate of Rush Medical College.

\*Fox, Wayne W., Evanston, died September 30 at the age of 68. Doctor Fox was a 1933 graduate of Cornell Medical School.

\*Forrest, Leslie B. J., Berwyn, died November 28 at the age of 57. Doctor Forrest was a 1935 graduate of the Chicago Medical School.

\*Goldschmidt, Heinz, Peoria, died November 3 at the age of 81. Doctor Goldschmidt was a 1921 graduate of Berlin University Medical School.

\*Hetreed, Francis W., Chicago, died September 30 at the age of 69. Doctor Hetreed was a 1933 graduate of the Loyola University Stritch School of Medicine.

\*Holub, Louis A., Berwyn, died November 24 at the age of 68. Doctor Holub was a 1935 graduate of the University of Illinois School of Medicine.

\*Horowitz, Herman L., Chicago, died November 5 at the age of 79. Doctor Horowitz was a 1923 graduate of Northwestern University Medical School.

\*Kaiserman, Frank B., Chicago, died December 3 at the age of 69. Doctor Kaiserman was a 1931 graduate of the University of Illinois School of Medicine.

\*Koch, Sumner L., Barrington, died November 1 at the age of 88. Doctor Koch was a 1914 graduate of Northwestern University Medical School.

\*Liebig, Gustave A., Chicago, died November 1 at the age of 63. Doctor Liebig was a 1939 graduate from Germany.

\*Perlia, Charles P., Evanston, died November 20 at the age of 51. Doctor Perlia was a 1952 graduate of the University of Basel in Switzerland.

\*Powers, Francis E., Oak Park, died November 1 at the age of 85. Doctor Powers was a 1919 graduate of St. Louis University Medical School.

\*Ruda, Joseph M., Palos Park, died November 14 at the age of 63. Doctor Ruda was a 1938 graduate of the Loyola University Stritch School of Medicine.

\*Rukstinat, George J., Chicago, died November 17 at the age of 77. Doctor Rukstinat was a 1925 graduate of the Rush Medical College.

\*Sacks, Martin O., Chicago, died November 28 at the age of 57. Doctor Sacks was a 1942 graduate of Toronto Medical School.

\*Sandeem, Henry W., Woodstock, died December 7 at the age of 83. Doctor Sandeen was a 1922 graduate of General Medical College.

\*Stocks, Joseph W., Chicago, died September 31 at the age of 83. Doctor Stocks was a 1923 graduate of Northwestern University Medical School.

\*Sullivan, Robert E., Park Ridge, died December 3 at the age of 51. Doctor Sullivan was a 1953 graduate of Loyola University Stritch School of Medicine.

\*Weller, Charles G., Aurora, died September 18 at the age of 81. Doctor Weller was a 1922 graduate of the University of Illinois School of Medicine.

\*Wiboro, Walter, Chicago, died September 30 at the age of 70. Doctor Wiboro was a 1934 graduate of Rush Medical College.

\*Indicates ISMS member.  
\*\*Indicates member of the ISMS Fifty Year Club.

### 1977 Travel Program

As a membership service the following travel programs will be offered in 1977:

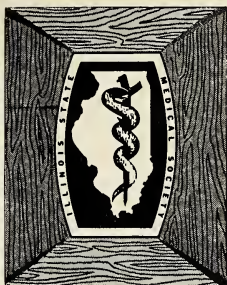
June 28-July 11: ALPS/RIVIERA ADVENTURE (Lausanne, Florence, Nice)

September 5-October 9: AROUND THE WORLD ADVENTURE

September 23-October 6: GREEK ISLES-BLACK SEA AIR/SEA CRUISE (Athens, Greek Isles, Dikili, Odessa, Yalta, Sochi, Istanbul)

October 14-23: LONDON-ROME DISCOVERY

Descriptive brochures will be mailed five months in advance. Reservations cannot be accepted without using the official form printed in these brochures. Persons outside a member's immediate family will be placed on a standby status until all ISMS members have had a reasonable time for making reservations. All promotional expense connected with these programs is paid by the tour operator. Contact Perry Smithers or Betty Duffy at ISMS headquarters for details.



# I M J

Illinois Medical Journal

Vol. 151, No. 1, January, 1977

## Increased Safety in Renal Transplantation

By J. LAURANCE HILL, M.D., SIMON J. SIMONIAN, M.D. AND  
FRANK P. STUART, M.D./CHICAGO

*The report reviews a series of 41 consecutive kidney transplants during a two year period with minimum followup of one year. For recipients of living related kidneys, 86% of the kidneys functioned beyond a year and all of the recipients survived more than a year. For recipients of cadaver kidneys, 56% of the kidneys functioned beyond a year and 94% of the recipients survived more than a year. Rejected grafts were removed and the patients were returned to maintenance hemodialysis. Factors responsible for the low mortality after transplantation are reviewed. The combination of low mortality, high degree of rehabilitation among recipients who keep their grafts, and low cost compared to chronic hemodialysis should encourage increased acceptance of kidney transplantation.*

Kidney disease has become the fourth leading health problem in the United States. Among eight million patients who suffer with renal disease, 58,000 die each year. It is the major cause of work loss for women of all ages, the second major cause among men less than 25 years old, and the fifth most common cause for men over 25 years. 4,000 children between the ages of 1-6 years are stricken with nephrosis every year.

For two decades physicians and scientists have struggled to sustain patients with end stage renal failure as functioning members in our society. From these efforts two effective modes of management have evolved: hemodialysis and transplantation. In Illinois, 1,550 patients require artificial renal support today. Since 1968, the number of Illinois residents on dialysis has doubled every two years. For the United States, this group numbered 23,000 at the beginning of 1976, and is predicted to increase more than 100,000 by 1980. Pressures from society to increase the availability and reduce the mortality and morbidity of kidney

transplantation will build as the number of patients on dialysis continues to increase. To meet these demands, the physicians and surgeons of the 50 dialysis units and 7 transplant centers in Illinois coordinate their efforts through a state-wide End Stage Renal Disease (ESRD) network. Networks have been created throughout the nation by the Social Security Administration which, in July, 1973, became the third party payor under Medicare for dialysis and transplant costs of 95% of Americans. Eligibility includes the entire families of workers who are covered by Social Security. This report inspects transplantation as a viable alternative to chronic hemodialysis at one of the 7 transplant centers in the Illinois network.

### Results of a Clinical Series

Forty-one patients received renal transplants at the University of Chicago Hospitals during the 24 months from January 1, 1973 to January

1, 1975, and have been followed for at least one year to assess clinical outcome. The average age in this group was 29 years; seven were younger than 18 or older than 40 years. Eighteen were female and the black/white ratio was 18/23. Three patients received a second transplant. Seven grafts were from living related donors; cadaveric sources supplied the remaining 34 grafts.

### Patient Survival

Thirty-nine of the 41 patients have survived for at least one year (95%). All of the recipients of living related grafts are alive, and 94% of recipients of cadaver kidneys are alive more than one year after transplantation.

Of the two patients who died in this series, the first in retrospect should not have been accepted as a transplant candidate. This 32-year-old man had a major lung infection in his left lower lobe three years prior to admission with residual loss of volume and "stable" fibrosis evident by roentgenogram. One week after transplantation and immunosuppression, fulminant *Pseudomonas* pneumonia recurred and spread from the fibrotic left lower lobe focus, causing his death 13 days after surgery.

The risk of a focus of chronic infection was redemonstrated by the second death. This 56-year-

old man, near the upper limits of age for consideration as a transplant recipient, was accepted because of his extraordinary insistence and apparent good health. In the previous year, however, he had been treated for prostatitis from which *E. coli* had been cultured before chemotherapy. On three occasions after antibiotics, repeat urine cultures after prostatic massage were negative. Nevertheless, 10 months following successful transplantation, his infection was reactivated and complicated by pneumonia. While in the hospital under treatment, a massive pulmonary embolus caused his death.

Twenty-seven months separated these two deaths; during the interval between them, 44 consecutive renal transplantations were performed without loss of life.

### Graft Survival

The term "graft survival" is defined as a life sustaining graft in place at least one year. With few exceptions, the serum creatinine is less than 2.5 mg%. For the entire series, 25 (61%) grafts have sustained patients at least one year free from dialysis.

For further evaluation, renal transplants are sub-classified into living related and cadaveric grafts; unrelated living donors have not been accepted. Six related (86%) and 19 cadaver grafts (56%) have sustained life for at least one year, and nearly all of them continue to function normally in the second year. Altogether, 16 grafts were lost (two from death and 14 from rejection). The two patients who died had received cadaver grafts that functioned normally until the time of death. Five grafts were removed because of unremitting rejection despite full immunosuppression. The other 9 grafts were rejected after reducing or discontinuing immunosuppression in the face of a life-threatening complication.

### Rehabilitation

Few deaths occur more than 6 months after transplantation, and mortality rates for transplant recipients beyond the first post-transplant year are less than for dialysis alone.<sup>1-3</sup> Moreover, the recipient of a successful transplant is usually fully rehabilitated. From the group of 25 patients in this series whose grafts have functioned for at least a year, 21 (84%) are fully rehabilitated as full-time employees, students or homemakers. Their emotional state is vastly improved

---

JOHN LAURANCE HILL, M.D. is assistant professor of surgery at the University of Chicago Hospitals and Clinics. His area of specialization is transplantation and pediatric surgery. Dr. Hill was a Schweppe Foundation Research Scholar from 1974 to 1976.

SIMON J. SIMONIAN, M.D., F.R.C.S. is assistant professor of surgery at the University of Chicago Pritzker School of Medicine. He is an attending surgeon in transplantation surgery at Michael Reese Hospital and the University of Chicago Hospitals where he is also on the Intensive Care Unit Committee, the Committee on Immunology, and Liaison Representative of the Department of Surgery to the Emergency Room Staff.



FRANK P. STUART, M.D. is professor of surgery at the University of Chicago Hospitals and Clinics. He is also a member of the Committee on Immunology, chief of the organ transplant service and faculty member of the Biological Sciences Collegiate Division. Dr. Stuart was a Markle Scholar in Academic Medicine from 1969 to 1974. His field of specialization is general surgery and renal transplantation.



and they are free from the burden of chronic hemodialysis which had occupied 18-20 hours each week. A side benefit to society is that transplantation with an average cost of \$10,000 is less expensive than dialysis in an outpatient center which costs \$25,000 each year.

### Comparison of Patient and Graft Survival with ACS/NIH Transplant Registry

The first long term successful human renal transplant was accomplished only 19 years ago. Since 1963, the Human Renal Transplant Registry (sponsored by the American College of Surgeons and National Institutes of Health) has collected worldwide data on more than 16,000 kidney transplants.<sup>1</sup> Data for survival of the recipient and the graft for 1966 and the most recent year reported by the Registry (1972) are shown in Table I. These numbers indicate that, although both living related and cadaveric grafts have not improved greatly in terms of organ survival, patient survival continues to increase steadily. For transplants performed in 1967 and 1972, the proportion of grafts still functioning one full year later was 75 and 76% for living related donors and 46 and 51% for cadaver donors. Nevertheless, survival of the recipient for at least one year increased from 80 to 88% for patients with living related grafts and from 56 to 72% for patients with cadaver grafts. Increased experience in managing transplant recipients has established the wisdom of abandoning the graft in favor of the patient's survival when faced with recurrent rejection and life-threatening complications.

**Table I**  
Correlation of Donor Sources with Survival of Recipients and Grafts at One Year

Year	Recipient Survival (%)		Graft Survival (%)	
	Living	Cadaver	Living	Cadaver
ACS/NIH Registry	1967	80	56	75
	1972	88	72	76
University of Chicago	1973	100	94	86
	1974			56

Recent experience at The University of Chicago compares favorably with the latest Transplant Registry report (Table I). The likelihood of graft survival for at least one year was modestly better and the chance for recipient survival

was much better. The recipient survival rates of 94% for cadaver grafts and 100% for related grafts compares favorably with the year end survival for dialysis without transplantation, which has an annual mortality of 9%.<sup>2,3</sup>

### Important Factors Increasing the Safety of Kidney Transplantation

The highest risk for transplant patients occurs during the first 6 months when immunosuppression is intense and defenses against infection are impaired. Reducing early mortality and morbidity through a variety of approaches has been a major objective of our transplantation program.

**Evaluation and Selection of Cadaver Donors.** Failure of a kidney to function immediately after transplantation complicates the postoperative management considerably. Dialysis with its heparin requirement may cause hemorrhage into the operative site. Regulation of fluid balance and drug therapy are more difficult. Cadaver donors should meet the following criteria: neurologic death with certainty of the absence of spontaneous breathing; not older than 55 years; free from abdominal sepsis, malignancy outside the central nervous system, and long-standing hypertension or renal disease; and a reasonable expectation for maintenance of a stable cardiovascular state and urine output for 12-24 hours. Ideally, the potential donor should be normotensive and excreting urine until the time of death and nephrectomy. However, patients who were in excellent health prior to a sudden terminal illness can still be considered for kidney donation even when hypotension and oliguria have been present for as long as 12-24 hours. Rehydration, diuretics, and vasodilators can usually restore good renal function even though serum creatinine levels had reached 3 to 4 mg/100 ml serum.<sup>4</sup>

The 7 transplant centers in Illinois coordinate the evaluation of potential cadaver donors and the retrieval of kidneys through the Association of Illinois Transplant Surgeons, a non-profit corporation with an office in Chicago adjacent to the Kidney Foundation of Illinois. A paramedical coordinator is always available to come to any hospital in Illinois to assist in donor evaluation and organ retrieval.<sup>5</sup>

Approximately 80% of kidneys function normally immediately after transplantation if they came from "beating heart" cadaver donors; kidneys are removed while the oxygenated arterial circulation is intact. Declaration of death in such

donors is based on irreversible cessation of total brain function. In September, 1975, Governor Walker signed into law an amendment to the Uniform Anatomical Gift Act that defined death for purposes of the Act as "the irreversible cessation of total brain function according to the usual and customary standards of medicine."<sup>4</sup>

**Temporary Organ Preservation.** Kidneys can be preserved at 4 to 10°C for as long as 72 hours by pulsatile perfusion with a variety of oxygenated solutions. Short term preservation allows enough time to take kidney transplantation out of the emergency surgery category and organize an elective or semi-elective procedure. Tissue typing for the Illinois network is centralized at the University of Illinois' Abraham Lincoln School of Medicine in Chicago. Usually, 6 to 12 hours are required to select the appropriate recipients from among all 1,550 dialysis patients in the network. The recipient is then admitted at the transplant center associated with his dialysis unit. Some recipients must travel as many as 6 hours to reach the transplant center. Furthermore, they may need to undergo hemodialysis for 4 to 5 hours before surgery. In most cases, transplantation is begun within 30 hours after removal of the cadaver kidney.

**Identification of Pre-immunized Recipients.** Dialysis patients frequently mount a transient antibody response against antigens present on leukocytes and platelets of transfused blood. Even though the antibody disappears months before the time of transplantation, the patient remains pre-sensitized. Transplantation of a kidney that reacted against those antisera would probably be followed by rejection. One of the most important functions of the central typing laboratory is to collect monthly serum samples from all dialysis patients and screen them for antibody reactions against a standard panel of transplant antigens. Much of the matching process immediately prior to transplantation has to do with avoiding selection of those recipients who have made antibodies that react with the available donor's antigens.

**Preoperative Evaluation by a Transplant Surgeon.** In all other areas of surgical practice, it is customary for the surgeon to evaluate the patient and make recommendations weeks or months before elective surgery. Altogether too often, however, the transplant surgeon and potential recipient meet for the first time after the patient has been selected by the typing laboratory to receive a particular cadaver kidney. If, at this late date, the surgeon rejects the selected

recipient for any reason, there may not be enough time to identify and prepare another recipient before the cadaver kidney sustains irreversible ischemic injury. Hence, transplant surgeons may proceed with patients who are not prepared optimally. Post-transplant mortality can be reduced if nephrologists and transplant surgeons meet regularly to review and select dialysis patients months ahead of time. Only by advance planning can chronic foci of infection (teeth, gums, lung, gallbladder, kidneys, prostate and urinary bladder) be eradicated prior to transplantation and immunosuppression. Moreover, the patient who has met the transplant surgeon ahead of time is less anxious and better informed about transplantation.

**Increased Willingness to Discontinue Immunosuppression.** Clearly, septic complications of immunosuppression are the major cause of death among transplant recipients. Current immunosuppressive agents (azathioprine, prednisone, local graft irradiation, and antilymphocyte serum) are not expected to improve graft survival much beyond current levels. The plateau that has existed since 1967 will continue until new approaches to immunosuppression are available. Meanwhile, those who direct the recipient's drug therapy must be willing to reduce immunosuppression drastically or discontinue it after two or perhaps three rejection episodes, or in the face of life-threatening infection. The rejected graft can be removed with little morbidity. The patient who has been restabilized on dialysis can always elect to try for another transplant. Renal transplantation is justified for most dialysis patients, even though only 50 or 60% of the grafts maintain long term function, as long as mortality during the first year does not exceed 10%. ◀

## References

1. Bergan, J. J., et al.: "ACS/NIH Twelfth Report of the Human Renal Transplant Registry." *JAMA* 233:7 (1975).
2. Burton, B. T., Krueger, K. K., Bryan, F. A.: "National registry of long term dialysis patients." *JAMA* 218:718 (1971).
3. Lindner, A., Charra, B., Sherrard, D. J., Scribner, B. H.: "Accelerated atherosclerosis in prolonged maintenance hemodialysis." *N. Eng. J. Med.* 290:697 (1974).
4. Stuart, F. P., Hill, J. L., Simonian, S. J.: "The cadaver kidney donor: selection, management, nephrectomy, and short term preservation." *Surg. Clin. N. A.* 56:7 (1976).
5. Footnote: Association of Illinois Transplant Surgeons, Suite 1338, 127 North Dearborn Street, Chicago, Illinois 60602. Business telephone (312) 263-3655, Donor telephone (312) 263-2140.

# Current Treatment of Essential Hypertension

By LOUIS C. JOHNSTON, M.D./CHICAGO

*A more assertive therapeutic attitude is considered paramount in urgently needed efforts to deal with the appalling prevalence of untreated hypertension in adults and adolescents in the United States.<sup>1-4,25</sup> This serious major risk factor of both myocardial infarction and stroke is demonstrably remediable for the latter and potentially so for the former. Patient compliance should not prove difficult as most respond to diet alteration and a long-acting natriuretic agent given once daily or only several times a week.*

High blood pressure is the single most powerful risk factor of both myocardial infarction and cerebral stroke.<sup>1,2</sup> It has been found on single visit screenings in 20 to 25 million adults in the United States, about half of whom may be expected to remain hypertensive on retesting, and in about 5% of adolescents, but twice that number in older youths and boys.<sup>2,3</sup> Only half of afflicted adults are aware of their condition and only an eighth are receiving effective treatment.<sup>4</sup> This clearly suggests the reasonableness of greater attention by clinicians to more assertive treatment and education of their hypertensive patients.<sup>4</sup>

A decision to institute drug therapy, however, must be tempered by an awareness that it will probably have to be continued for a lifetime, that it necessitates the conversion of a person into a patient, and that the data supporting benefits of therapy become evident in most only after about a decade, although earlier in more severe grades of hypertension.<sup>5,6</sup> Thus the ever present dilemma: are the detrimental side effects of the drug, even though slight, greater or lesser than the untreated consequences of hypertension in any particular patient? While it is widely recognized that the incidence of such immediate pathologic consequences of severe hypertension as cerebral hemorrhage, heart failure and acute

encephalopathy are dramatically reduced by therapy,<sup>5</sup> data is now appearing which also appears to document decreasing morbidity via prolonged drug therapy of milder hypertension.<sup>6</sup> This partially completed massive Public Health Study, more than the earlier Veterans Administration study of men,<sup>5</sup> specifically addresses itself to results of treatment of mild hypertension and of both men and women. In this group hypertension is best viewed as simply another "risk factor" of ischemic heart disease, albeit the single most powerful of the remediable factors. (Figure) Equal attention should therefore be given to cigarette smoking, obesity, serum lipids and blood sugar, even though definitive prospective studies relating treatment of risk factors to subsequent incidence of myocardial infarction are yet under way.

## Borderline or Labile Hypertension

This category demonstrates modest elevations on most office visits (150-160/90-100) with occasional values and most home values, below 140/90 mmHg. No target organ disease is present such as left ventricular hypertrophy, retinopathy, proteinuria or other evidence of hypertensive vascular disease of the heart, brain or kidney.<sup>8</sup> This is the most common category of hypertension with a prevalence in this country approaching 15% of the general population. While drug therapy is not indicated, continued observation is, as 10-15% of such patients develop sustained hypertension within two decades. This group should simply be observed, perhaps 2 to 3 times a year, and they should avoid things known to exacerbate mild or labile disease: obesity, licorice (salt retaining), salt and estrogens as commonly employed in menopause therapies and birth control pills.<sup>1</sup>

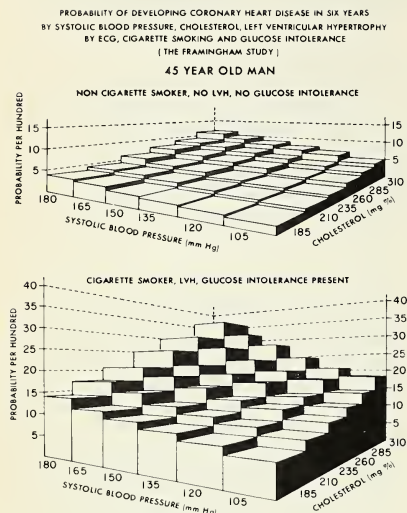


LOUIS C. JOHNSTON, M.D., is Medical Director and Director of Medical Education at Grant Hospital in Chicago. He is also an Associate Professor of Medicine at Northwestern University Medical School.



Figure 1\*

## Mild Hypertension



The United States populace consumes an average of about 10-12 grams (200 mEq) of NaCl daily. Many consume twice as much! This can easily be reduced to 5-6 grams (100mEq) by excluding such salty foods as potato chips, pickles, ham, sausage, excessive cheese, and the salt shaker from the table. By not adding salt to the cooking this figure can be lowered to 2-4 grams daily, the level at which these patients should be maintained. Restaurant meals are a danger as "seasoned meals" are usually simply salty meals. If contraceptive steroids or estrogens are administered the pressure initially should be monitored monthly. Their discontinuation may be forced in some because of subsequent serious pressure rises. Obesity, or even a substantial weight gain among the nonobese, should be dealt with firmly, particularly regarding stroke prophylaxis.<sup>9</sup>

In mild hypertension all diastolic readings are over 90 and an average of readings obtained over at least three office visits lies between 90 to 104 mmHg.<sup>8</sup> Although controversial earlier, drug therapy is now advocated for most of this group, but exceptions are not infrequent. While there is little statistical support for drug therapy of a 68-year-old woman, 150 or 160/95, and without end organ change, such therapy would be unquestionably warranted in a young black male with the same pressures, or one with a parent distinctly hypertensive before age 55 or 60, or a younger patient with several "risk factors." Mortality risks are about normal in the above older woman, but eight to ten times normal, even with the same pressure, with the addition of several "risk factors." (See Figure) As years of therapy are necessary to document benefits, there is no reason here for undue hastiness in gathering pre-treatment information well before commencing therapy, especially multiple pressure recordings on different days and data to exclude secondary hypertension.<sup>1</sup>

The drug of choice for most here is a long acting diuretic type agent because most patients in this category can be very effectively managed by this alone and not be further concerned with dietary salt intake apart from avoiding a high salt diet. An entirely acceptable although unpopular alternative is the demanding Kempner "rice fruit diet" with 300 grams of rice daily, 20 gm of nonanimal protein, 5 gm fat, 150 mg Na and added fruit juice to make 2000 kilocalories, altered somewhat with the presence of complicating obesity.<sup>10</sup> This diet, used alone, often suffices for moderate and even severe grades of hypertension, while a slightly less stringent modification is often adequate for mild or borderline pressure elevations.

If diuretic drug therapy is elected, the less frequent administration of the longer acting diuretics is preferable and patient compliance thereby enhanced. Methyclothiazide (Enduron), polythiazide (Renese), trichloromethiazide (Naqua) and the longest acting, chlorthalidone (Hygroton) never need be given here more than once daily, the latter often only several times a week. Visits during the first several months of therapy allow regulation to minimum dose necessary which, for example with chlorthalidone, may vary from 200 mg a day to 25 mg three times a week. Most patients can be well managed on such a single drug regimen.<sup>1,11</sup>

\*Figure by Nemat O. Borhani, M.D., "Implementation and Evaluation of Community Hypertension Programs," reprinted from *Epidemiology And Control of Hypertension*, page 638, Symposia Specialists, P.O. Box 610397, Miami, Florida 33161.

### Noted Side Effects

Minimizing dosage serves to limit the drug induced abnormalities of potassium (K), glucose and, if as low as several times weekly, uric acid blood levels. K loss here is obligatory, as it is dependent upon a compensatory hypermineralo-steroid response to therapy which leads to an increased rate of exchange in the distal renal tubule of Na (in) for K or H<sup>+</sup> (out) with resultant hypokalemic hypochloremic metabolic alkalosis, minimized by utilization of the lowest dose necessary and copious use of such K rich foods as bananas, orange juice and fruits. Additional K can be satisfactorily given as 10% KCl. This may occasionally cause GI mucosal erosion with bleeding if it is not taken well diluted, 15 ml (20 mEq) in a glass of water or milk and only after meals. If serum K remains low after several months of this, spironolactone (Aldactone), usually only 50 mg, once or twice a day, or trimterene (Dyrenium) 100 mg once or twice a day should be used in place of the liquid KCl. The latter must be initially stopped first, lest the combination lead to potentially dangerous hyperkalemia. If K remains low despite these measures, hospitalization would be in order for a more careful search for an aldosteronoma.

As these antihypertensive sulfonamide derivatives blunt insulin release and carbohydrate oxidation at the level of the Krebs cycle,<sup>1,11</sup> minimizing diuretic dosage limits induced hyperglycemia. The latter mandates the introduction of a diabetic diet and vigorous attention to obesity. In the rare event that pharmacotherapy is additionally necessary, insulin and not oral agents is now the choice with the latter reserved for such exceptional circumstances as poor vision or mental handicaps.<sup>12</sup> Potassium depletion itself may cause carbohydrate intolerance as does frank uremia.

At low doses thiazides cause renal retention of urate, often with substantial hyperuricemia. As most of this population, and all of those with "moderate hypertension" (see below), already have benign nephrosclerosis, it may be important to control this hyperuricemia with its attendant but as yet unproved threat of additional renal interstitial injury. Allopurinol (Zyloprim) is useful, 100 mg t.i.d. usually suffices. It should be in combination with a "not high" purine diet, one avoiding excessive meat and such highly parenchymatous foods as liver, kidney, tongue and sweetbreads.

Despite such troublesome comments, most patients can take these drugs for years and remain entirely symptom free. Treatment usually is life-long; only rarely do patients remain normotensive after drug withdrawal, and then only after several years of exceptionally good antihypertensive control.<sup>13</sup> Patients need encouragement to stay on treatment, especially during the first month or two when pressure is lowered primarily by volume contraction and decrease in cardiac output with the associated and predictable complaints of "weakness" and "low energy." Shortly, however, usually after a month or two, cardiac output normalizes and volume factors almost do but pressure remains low due to decreased peripheral resistance.<sup>1,11</sup> Symptoms now abate, with sensations of strength and energy returning to their previous state.

The preferable starting drug in the setting of frank or latent diabetes or gout is spironolactone (Aldactone), commonly 0.1 gm daily in divided doses which, while more expensive, will normalize pressures of most office patients even when used alone.<sup>14</sup> It is a competitive metabolic inhibitor of aldosterone and as such presents no difficulties of carbohydrate intolerance, hyperuricemia or potassium depletion. Certain patients with frank or even marginal renal insufficiency, e.g., BUN 28 or 30 mg/100 ml, may slowly develop hyperkalemia, even to dangerous levels, or hyponatremia requiring downward dose adjustment.

Infrequently these drugs will not adequately manage pressures even in this mild group and additional drugs must be added.

### Moderate Hypertension

The classification of moderate hypertension refers to those with average office diastolic recordings between 105 and 115 mmHg.<sup>8</sup> Here only a couple of visits to document this level of pressure suffice to start therapy, especially in the presence of obvious end organ target disease, which at this level is usually discernible. A sulfonamide-type drug alone often proves adequate, but if not, one of several drugs may be added: reserpine (Serpasil) hydralazine (Apresoline) or methyldopa (Aldomet).<sup>1,8,11</sup> Reserpine is the most popular, 0.25 mg daily, and unquestionably shows an additive effect. Less well appreciated but very thoroughly documented is that oral reserpine, when used alone, is not more effective than placebo! This is incontestable, even using unusually large doses, 0.5-1.0 mg daily.<sup>15</sup> Its use, even in combination, has been at least temporarily shadowed

by recent controversy, as yet unsettled, regarding its possible epidemiologic linkage to breast cancer.<sup>16</sup> Like methyl dopa, it is quickly absorbed, penetrates fat and is rapidly distributed throughout the brain with resultant drowsiness, blunting of intellectuality and sometimes depression which is occasionally severe. Chronic sinusitis and peptic ulcer are additional contraindications to this complicated six-ring agent which releases and then impairs intracellular storage of a variety of catechols such as norepinephrine (NE), dopamine and serotonin in the brain, peripheral adrenergic nerves, heart, chromaffin tissue and platelets. These effects are prolonged and there is never need to administer this drug more than once daily.

Methyl dopa inhibits the synthesis of catechols but its major mechanism is that of a "false neurotransmitter".<sup>1,11</sup> It is taken up by nerve endings and secreted as alpha methyl NE, and subsequently attaches to adrenergic receptor sites thereby rendering them unavailable to the naturally secreted NE. When added to thiazide, it often is started at .25 gm b.i.d. and then increased as needed to a top or "plateau dose" of 2.0 or even 3.0 gm a day, divided into four doses. Somnolence and exercise induced postural hypotension may become problems, therefore the pressure at the office should occasionally be checked immediately after such exercise as running in place or rapid corridor walking. About a fifth of patients here develop various antibodies (Coombs, LE, RA) and a smaller number develop frank hemolytic anemia, drug fever or serious hepatitis; therefore, it should not be used in patients with liver disease.<sup>17</sup> This drug is particularly useful in renal insufficiency as it does not lower either cardiac output or renal blood flow.

Hydralazine may be added to thiazides, or to either of the above two combinations if needed.<sup>1,11</sup> It is commonly begun at 10-25 mg b.i.d. and then increased gradually, when necessary, to 50 mg q.i.d. as maximum dosage—larger amounts often give rise to a potentially dangerous RA-LE syndrome in approximately 10 per cent of patients taking more than 0.4 gm daily. This reaction almost always proves reversible upon stopping the drug but such reversion may take a year. Drug fever and rash occur only rarely at lower doses; palpitation, headache and angina exacerbation occasionally necessitating drug interruption are more common side effects of this direct vasodilator, with its resultant marked increase in cardiac output, pulse rate and pulse pressure. Flow is thereby increased to gut, kidney, and

brain. This response of increased cardiac output can be effectively and chronically blocked by average oral doses of propranolol (Inderal) which largely explains its unique antihypertensive effectiveness when added to a hydralazine regimen.

### Unresponsive or Severe Hypertension

The treatment plans outlined above adequately control blood pressure in all but a few of these patients. For them additional and more powerful therapeutic modalities become less conservative than a second and more sophisticated search for an underlying remediable lesion and its surgical correction. Clearly outlined procedures for uncovering renal artery stenosis, aldosteronoma and pheochromocytoma are readily available by chapter title and should now be pursued with vigor.<sup>1,11</sup> It should be restated, however, that the canon of the clinician must remain that of undertaking no unusually hazardous or expensive diagnostic exercise unless the appropriate surgery will actually be recommended if the condition being sought is found. There is little data to support, for example, angiography or arterial surgery for demonstrated renal artery stenosis in an older hypertensive patient with significant generalized arteriosclerosis.

Most of these nonresponding patients will fail to demonstrate a surgically remediable lesion and must be treated as severe hypertension with mean diastolic pressures usually over 114 mm Hg.<sup>8</sup> Some will have to be hospitalized for treatment as an emergency (see below). The mainstay of further management is the addition of guanethidine (Ismelin) to the previous diuretic and methyl dopa or hydralazine regimen.<sup>1,11</sup> It is usually started at 10 mg, and only once daily as it is very long acting. Doses may be gradually increased to 300-400 mg daily, and are best administered by the patient (or an instructed spouse or friend), recording his own standing pressure and adjusting the dose on that particular day to his systolic pressure observed midday or at least one hour after rising. This drug depletes heart and adrenergic nerve terminals of catechols and blocks response to adrenergic nerve stimuli, but not at the ganglion level. This leaves cholinergic function intact and therefore constipation, urinary retention and dry mouth are not problems. It does not penetrate brain so the drowsiness and obtundation of reserpine, methyl dopa, and clonidine (Catapres)<sup>18</sup> are not seen. Failure of ejaculation is seen, however, but without loss of potency. Exertional hypotension



**Table**  
**Emergency Parenteral Antihypertensive Drugs**

Drug	Method of Administration	Dose	Onset of Action	Comments
Sodium Nitroprusside <sup>1,3</sup> (Nipride)	IV drip (titrate BP)	50 mg ampule/liter (30-200 mcg/min)	1-2 min with prompt offset	Requires constant monitoring
Trimethaphan (Arfonad)	IV drip (titrate BP)	1.0-2.0 gm/liter or 1-2 mg/ml	3-4 min with prompt offset	Requires constant monitoring, and "head up-legs down" position.
Diazoxide <sup>1,3</sup> (Hyperstat)	IV "push" from syringe	300-600 mg, a single swift bolus injection	1-2 min, lasts 6-8 hr	Often nausea at time of injection. After 1-2 days, edema and hyper- glycemia common. No opportunity for titration.
Hydralazine <sup>1,3</sup> (Apresoline)	IV or IM	10-40 mg, single injection or 100 mg/liter as slow infusion	30-40 min, lasts 4-6 hr	Often headache, flushing tachycardia and palpitation.
Reserpine <sup>2</sup> (Serpasil, Sandril)	IM	1-5 mg	1.5-2 hr, lasts 12 hr	Delay in onset of action and drowsi- ness is common. Observe BP first after a "test dose" of 0.2 mg IM. (Some quite sensitive)
Methyldopa <sup>1,2</sup> (Aldomet)	IV (30 min. infusion)	250-500 mg in .0-2 liter	4-6 hr, lasts 8-12 hr	Delay in onset of action and drowsiness are common.
Pentolinium (Ansolsen)	SQ or IM ..... IV single dose ..... IV infusion .....	1-20 mg 1-20 mg 0.5-2 gm/liter	10 min, lasts 6-8 hr	Necessary to use "head up-legs down" position. Also blocks para- sympathetics (ileus, urinary reten- tion).
Phentolamine (Regitine)	IM ..... IV single dose ..... IV infusion .....	5-10 mg 5-10 mg (rapidly) 2-4 gm/liter	5 min, lasts ½ hr	Effective only if excessive catecho- lamines present; e.g., pheochromo- cytoma or "crisis" in patients on MAO drugs after aged cheese, etc.

<sup>1</sup>Does not lower renal blood flow.

<sup>2</sup>Delay in onset impairs usefulness in some emergencies.

<sup>3</sup>Resultant increase in cardiac output may worsen angina.

should be sought and troublesome diarrhea may occasionally require, for example, tablets of combined atropine and diphenoxylate, (LoMotil). Amphetamines (even Dexamyl) and tricyclic antidepressants (Elavil, Tofranil) blunt or block the effectiveness of guanethidine.<sup>11</sup>

### Emergencies

Emergencies are best managed via immediate hospitalization whenever possible. They are encompassed for the most part by acute toxemia of pregnancy, acute pulmonary edema, malignant hypertension and acute encephalopathy.<sup>1,19</sup> Less common circumstances are certain pressor phases of acute glomerulonephritis (especially in children), acutely dissecting aneurysm of the aorta,

certain cerebral hemorrhages, discharging pheochromocytomas (commonly after unrelated major surgery or obstetrical delivery) and tyramine ingestion (aged cheeses, certain red wines and beers) by patients on such monamine oxidase inhibiting drugs as Eutonyl, Marplan, Niamid or Nardil. All require immediate lowering of blood pressure, usually by parenteral means and by an agent that does not lower renal blood flow if renal insufficiency is present (see Table).<sup>20</sup> An extremely potent oral vasodilator will soon be available for this latter circumstance (minoxidil).<sup>1</sup>

Acute encephalopathy is recognized as a sudden serious neurologic deficit, e.g., aphasia, hemiplegia or badly blurred vision, which proves transient on prompt and adequate lowering of



the associated extremely elevated pressure.<sup>1,19</sup> The pathology includes diffuse microthrombi in small cerebral vessels and cerebral edema with total brain weights 20% to 30% higher than normal, flattened convolutions and spinal fluid pressures greatly elevated, often to over 500 mm of water. Diffuse extreme narrowing of retinal arteries is present on ophthalmoscopy. In travenous diazoxide (Hyperstat) is usually satisfactory with precautions to avoid extravasation (local irritation). If used longer than a few days furosemide (Lasix, 40-120 mg/day, oral or IV) must also be given because of fluid retention. An acceptable alternative is nitroprusside (Nipride) by continuous intravenous infusion which virtually never fails to lower pressure but carries the disadvantage of requiring diligent bedside blood pressure monitoring. After a day or so of nitroprusside, fluid retention may become a problem (furosemide again). Compensatory increased baroreceptor activity is commonly induced with associated marked sinus tachycardia and palpitation.<sup>19</sup> This usually can be effectively handled with propranolol, oral or IV, which in turn permits considerable decrease of dosage of the nitroprusside (see Table).

Malignant hypertension is the clinician's counterpart of the pathologist's malignant nephrosclerosis.<sup>1,19</sup> Descriptions are classic and include papilledema, severe hypertension, proteinuria and hematuria—microscopic evidence of the latter often being the earliest sign. This should be viewed by the clinician himself taking care to examine only midstream specimens in women, and may comprise as few as four or five RBC's and a blood cast per centrifuged high power field. Plasma renin is almost always extremely elevated, 5-10 fold per unit of salt balance.<sup>21</sup> Any of the top seven drugs of the Table, often in combination, usually prove adequate. The specific selection is usually dependent, and properly so, on the experiences of the therapist. It is best to push aggressively even if renal insufficiency temporarily worsens to the extent of requiring dialysis. Substantially decreasing the blood pressure allows healing of the arteriolar acute fibrinoid necrosis.<sup>22</sup> Only very rarely is bilateral nephrectomy necessary,<sup>23</sup> especially now with the imminent availability of minoxidil, mentioned earlier.

Other emergency states are handled similarly. Acute hypertensive left heart failure (rales, gallop, alternans) rarely permits the lengthy induction of reserpine or methyldopa. It is usually greatly benefited by concomitant usage of parenteral antihypertensives and an IV "loop diuretic,"

furosemide (Lasix) or ethacrynic acid (Edecrin), each 40-100 mg. Such routine measures as sitting position with legs down, digitalis, morphine and tourniquets should also be used.

Regarding aortic dissection, a regimen of medical intervention has been developed with improved salvage and when necessary of "buying time" for preparation for surgery.<sup>20,24</sup> The preferred drug selection, reserpine, propranolol and trimethapan (Arfonad), all parenterally given, aims at both lowering the systolic pressure to 100-120 mmHg and decreasing the vigor of myocardial contraction and pulse propagation.

There are very few areas indeed in clinical medicine where indications for treatment are so solidly founded and effective therapy so readily available. A clarion call to more widespread therapeutic assertiveness is in order, and by the source to whom most will turn for such advice, the clinician.<sup>25</sup> ◀

#### References

A complete bibliography for "Current Treatment of Essential Hypertension" may be obtained by writing the Illinois Medical Journal, 55 E. Monroe, Suite 3510, Chicago 60603.

### COOK COUNTY

#### Graduate School of Medicine

#### CONTINUING EDUCATION COURSES

#### STARTING DATES - 1977

REVIEW NEUROLOGICAL SURGERY, February 4  
SPECIALTY REVIEW PEDIATRIC SURGERY, February 14  
SPECIALTY REVIEW THORACIC SURGERY, February 21  
SPECIALTY REVIEW SURGERY, PART II, March 14  
NEUROLOGY, Part I, Basic, March 14  
BASIC INTERNAL MEDICINE, One Week, March 14  
NEUROPATHOLOGY, One Week, March 21  
DIAGNOSIS & MANAGEMENT OF PROBLEMS IN GYNECOLOGY, March 21  
BASIC EKG, One Week, March 21  
EKG FOR ANESTHESIOLOGISTS, One Week, March 21  
ADVANCED EKG, Two and a half days, March 28  
SURGERY OF THE G. I. TRACT, One Week, April 11  
SPECIALTY REVIEW PEDIATRICS, One Week, April 11  
DIAGNOSTIC RADIOLOGY, One Week, April 11  
SPECIALTY REVIEW UROLOGY, One Week, April 20  
STATE & NAT'L. BD. REVIEW, BASIC, April 24, CLINICAL, May 2  
FAMILY PRACTICE REVIEW, One Week, April 25

*Information concerning numerous other continuation courses available upon request.*

#### Address:

REGISTRAR, 707 South Wood Street,  
Chicago, Ill. 60612

# School Screening for Scoliosis

BY DANIEL C. NEWMAN, M.D. AND RONALD L. DEWALD, M.D./CHICAGO

*The purpose of this paper is four fold: to determine the incidence of scoliosis in the Illinois population; to describe a method of conducting a scoliosis school screening program; to suggest a reasonable program for follow-up; and to gather evidence in order for scoliosis screening to become a routine requirement in our Illinois school systems.*

## Literature Review

Previous scoliosis prevalence studies have demonstrated a variety of samples, definitions and criteria resulting in a wide range of results.

Shands and Eisberg,<sup>1</sup> 1955, analyzed 50,000 mini-films made during a survey for tuberculosis in Delaware. They determined that 1.9% of the population over the age of 14 had scoliosis with curves of 10° and greater and that 0.5% had scoliosis of 20° or greater. Approximately 2/3 of these were felt to be postural. An incidence of 3.5 females to one male was found.

Patinski, et al.,<sup>2</sup> 1957, examined 5,000 children ages 7 to 15 and found an incidence of scoliosis of 2.56% with 0.12% having curves greater than 30°.

Braszewski and Kamza,<sup>3</sup> 1957, studied 15,000 serial roentgenograms. They found an incidence of scoliosis of 3.7%. These were divided into mild, moderate and severe curves with an incidence of 3.08%, 0.46% and 0.15%, respectively.

Ruth Wynne-Davies,<sup>4</sup> 1968, did a survey of Edinburgh Schools, nursery schools and infant clinics to determine the family incidence of scoliosis. A rib hump on forward bending was the criterion for screening followed by roent-

genographic examination. She found an incidence of scoliosis of 0.13% under the age of 8 years and of 1.8% in the children 8 years of age and older.

Kane and Moe,<sup>5</sup> 1970, found a prevalence rate of at least 0.133% for scoliosis requiring referral to an orthopedist in Minnesota for individuals born in 1950. A ratio of 5 females to one male was found. The prevalence is probably conservative because of the criterion that the patient was to be referred to an orthopedist.

Brooks, et al.,<sup>6,7</sup> 1972, conducting a prospective study of children 12 to 16 years of age, found the incidence of scoliosis to be 11% in California. The ratio of females to males affected was 3 to 2. In 1975 he reported the incidence to be 13%.

## Material and Methods

Our survey was done at a public high school in the Chicago area with the consent of the superintendent of the school district. We conducted our survey in a similar manner to Brooks, et al. All of our screening was done in one school day. The initial examination was conducted by physical therapists and orthopedic nurses from Rush Medical College. The criteria for a positive examination was asymmetry of the shoulders, trunk imbalance, asymmetry of the pelvis or evidence of fixed vertebral rotation on forward bending. A physician then saw each child felt to have any of these criteria. An AP standing X-ray was ordered by the physician only in those students who demonstrated fixed rotation on forward bending. Lateral X-rays were included if a structural roundback was suspected.

All students examined were required to have a signed parental consent. The boys wore gym trunks and the girls wore gym trunks and bras. Eight hundred and sixty-one students were examined. Students with positive exams were offered an X-ray, free of charge, at Shriner's Hospital for Crippled Children in Chicago. To obtain an X-ray, a second parental consent was required.

---

DANIEL C. NEWMAN, M.D. is an associate in orthopaedic surgery at Shriners Hospital for Crippled Children and Grant Hospital. Dr. Newman's special area of interest is spinal surgery.



Illinois Children's Hospital School, Holy Family Hospital, Shriners Hospital for Crippled Children and Hines Veterans Administration Hospital.

RONALD L. DE WALD, M.D. is professor in orthopaedic surgery at Rush Medical College and senior attending orthopaedic surgeon and chief of the Section for Spinal Surgery at Presbyterian-St. Luke's Hospital. He is also a faculty lecturer at the Rehabilitation Institute of Chicago, Northwestern University; a consultant for the Illinois Division of Services for Crippled Children,

## Results

Examination of the 861 high school students yielded 156 positive exams. This represents 18.1% of the total. 372 boys were examined with 40 positive exams and 469 girls were examined with 116 positive exams. 156 students were then offered a free X-ray. Only 98 of these students obtained the required second parental consent and had the X-ray taken. We have no reason to believe these 98 students were selected any way but randomly.

The X-rays were evaluated and the curves measured by the method of Cobb.<sup>8</sup> The vertebral body rotation was estimated by the method of Nash and Moe.<sup>9</sup> The X-rays were divided into four groups: 0 to 4 degrees of curvature, 5 to 9 degrees, 10 to 14 degrees, and 15 degrees or greater. If two curves were measurable on any one patient, the curve of greater magnitude was used to determine which category the patient fell into. If two curves were measured of equal magnitude, this was considered to be a double structural curve. This may not be truly accurate but for the purposes of this study, we felt that it was valid.

The division of the curves by the magnitude of the Cobb angle was as suggested by Brooks, et al, and use of his divisions would enable us to compare our results with the California study. The curves that measured 0 to 4 degrees were considered to be negative exams. Eighty-seven of the 98 students who had X-rays taken had curves of 5° or greater. If we assume that the incidence of 5° or greater curves could be the same for all 156 positive exams, 138 students out of the total 861 would have such curves. This represents an incidence of 16%. This is consistent with the findings of Brooks. The incidence of curves greater than 5° in boys was 10.1% and in girls 21.4% for a female to male ratio of 2 to 1.

The distribution of the curves by degree of Cobb angle is seen in Table I. Table II shows

**Table I**  
Distribution of Cases by Degree of Curvature  
in Boys and Girls

Degrees	Boys		Girls	
	Number	% of Boys	Number	% of Girls
0-4	2	6.3	9	13.6
5-9	13	40.6	18	27.3
10-14	12	37.5	20	30.3
≥ 15	5	15.6	19	28.8

**Table II**  
Distribution of Cases by Location of  
Curvature in Boys and Girls

Location	Boys		Girls	
	Number	% of Boys	Number	% of Girls
Thoracic	15	50	14	24.6
Thoracolumbar	5	16.6	21	36.8
Lumbar	8	26.6	18	31.6
Double Major	2	6.6	4	7

the distribution of the curve as to the area of the spine involved. In this study the thoracolumbar curves were defined as those with the apex of the curve from T11 to L1. Table III shows the dis-

**Table III**  
Distribution of Cases by the Direction of the  
Convexity of the Curve in Boys and Girls

	Boys		Girls	
	Number	% of Boys	Number	% of Girls
Right	10	33.3	25	43.9
Left	18	60.0	28	49.1
Double	2	6.6	4	7

tribution of the curves as to right or left. Our series is still too small to define definite trends and that was not the purpose of our study. Throughout this paper we assume that the curve of the greatest magnitude was the major or primary structural curve and this may not be so. The amount of vertebral rotation was not considered. It is interesting that of the 11 cases in which the curve measured 4° or less, 6 of these have vertebral body rotation of at least 1+ which explains why they were picked up on our initial examination.

## Discussion

The primary objective of this paper was to determine the incidence of scoliosis in the high school population of Illinois. We accomplished this with a large sample and adequate X-ray evaluation. If school screenings are to be useful in detecting early scoliosis so that treatment may be initiated before significant progression, they must be done with a much younger group of patients. Screenings should be done yearly from age 8 through age 16.

The important question, which must be answered, is how do we determine which of the 8 year olds with detected 5° curves will progress



their curves. Early recognition of the curve and early treatment are the primary goals but we must not overtreat. Bracing a curve which will not progress can do severe psychological damage to a developing teenager. Large scale screenings are now being carried out in Delaware, Minnesota and California on younger patients where early recognition and treatment is the goal. There are now follow-up studies forthcoming which may help us predict which of these cases will progress. At the present time, the X-rays from our school survey are being entered into the computer at the University of Illinois Circle Campus to be compared with a group of X-rays of patients who required Milwaukee brace treatment, and a group of patients who have been observed for a number of years and have not required treatment.

### School Screening

There are several preliminary steps which should be followed in setting up a scoliosis screening program. Planning for the school screening should include consulting the school administrators and school health authorities. This is essential if screening is to become a part of the total school health program. The local medical societies should be solicited for their support. Their participation will be necessary to carry out the screening and to establish a viable follow-up program.

We feel that we have some workable suggestions for carrying out the actual screening program. First, a team of persons to do the screening will be needed. A short time spent with nurses, physical therapists, and physical education instructors will make them competent to screen large numbers of patients. Some states have scoliosis training workshops where screeners can be taught the simple evaluation for spinal deformity.

The school health officials should then inform the parents and other school officials of what the screening will entail. The use of one of several excellent movies available can simplify this task. Letters to the parents explaining the program are essential. Publicity through the news media throughout the community may be beneficial.

The time and place is then selected. We performed our screening during the physical education classes. We were easily able to see a large number of students without disrupting classroom routine. Written parental consent must be obtained and on file prior to the screening date.

Orientation of the students again through the

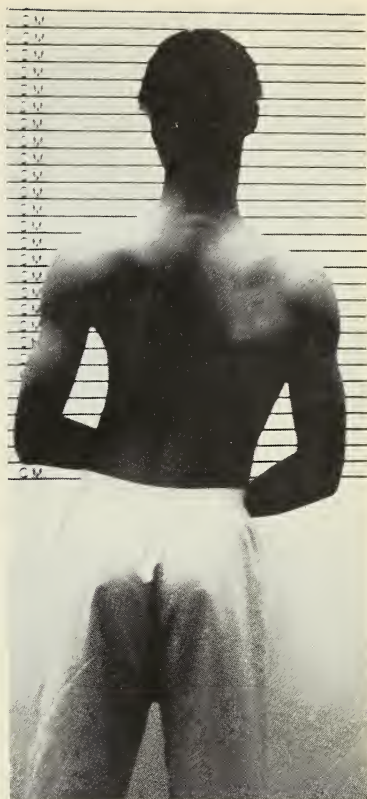


Figure 1a. This patient demonstrates shoulder and pelvis asymmetry and trunk imbalance.

use of one of the scoliosis movies and demonstrations of what the screenings will actually be like will be helpful prior to the actual date of screening.

As stated before, our screening was done by nurses, physical therapists and physical education instructors. They were taught to look for shoulder and pelvis asymmetry, trunk imbalance and fixed vertebral rotation on forward bending (Figure 1A and 1B). The forward bending test is the most important part of the screening. A physician then saw each student suspected to have a positive exam and, if he concurred, an X-ray was ordered.



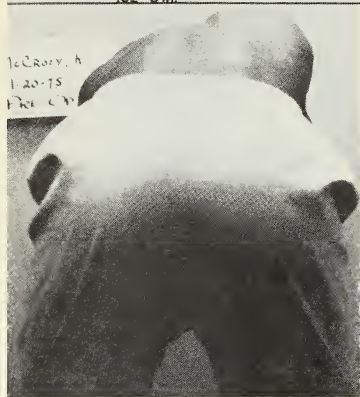


Figure 1b. The same patient demonstrating fixed vertebral rotation on forward bending.

Those students with positive exams in our study were fortunate to have an X-ray offered free of charge. If no X-ray facilities are available, students should be referred directly to their family physician, pediatrician or orthopedic surgeon. We would hope that the members of the medical community will recognize the importance of early detection of scoliosis and obtain an initial X-ray on each child referred to him. Some curves will seem to be insignificant but without an initial film, detection of progression of the scoliosis will be delayed. School health officials should follow-up each student at this point to be sure that he has been seen by a physician. After the initial X-ray evaluation follow-up X-rays should be taken at yearly intervals in most cases and every six months in those students who are in their rapid growth spurt.

The treatment of scoliosis is beyond the scope of this paper. Generally, curves less than  $15^\circ$  will not require treatment. Curves greater than  $15^\circ$  or those which show documented progression should be considered for treatment. We again want to stress that over-treatment is no more desirable than undertreatment.

## Summary

First, we presume 16% of high school students in Illinois have scoliosis. Second, we have demonstrated that school screenings are possible, practical and necessary. Thirdly, the state legislature should be aware of the magnitude of the problem and scoliosis screening should be mandatory.

The importance of scoliosis school screenings is emphasized in this statement of July, 1974: "The American Academy of Orthopedic Surgeons hereby gives its official recommendation to any program of routine examination of school children for the detection of scoliosis and other crippling spine deformities. The Academy recognized that, by early detection, more appropriate treatment can be given and a better total treatment of this disabling health problem can be carried out."

## Reference

1. Shands, A. R., Jr. and Eisberg, H. B.: "The Incidence of Scoliosis in the State of Delaware. A study of 50,000 Mini-films of the Chest Made During a Survey for Tuberculosis." *Journal of Bone and Joint Surgery* 37-A:1243-1249, Dec. 1955.
2. Patinski, J., Szczekot, Jr., and Sewaluk, F.: "The Incidence of Scoliosis." *Chir. Narzad. Ruchu Ortop. Polska*, 22:111-114, 1957.
3. Braszewski, J. and Kamza, Z.: "The Incidence of Scoliosis on the Basis of Serial Radiography." *Chir. Narzad. Ruchu Ortop. Polska*, 22:115-116, 1957.
4. Wynne-Davies, Ruth: "Familiar (Idiopathic) Scoliosis." *Journal of Bone and Joint Surgery*, 50-B:24-30, February, 1968.
5. Kane, William J. and Moe, John H.: "A Scoliosis Prevalence Survey in Minnesota." *Clinical Orthopedics*, 69:216-218, 1970.
6. Brooks, Leon, et al.: "The Epidemiology of Scoliosis—A Prospective Study." *Orthopedic Review*, 1:17, November, 1972.
7. Brooks, Leon, et al.: "Scoliosis: A Prospective Epidemiological Study." *Journal of Bone and Joint Surgery*, 57-A:968-972, October, 1975.
8. Cobb, J. R.: "Outline for the Study of Scoliosis." *Instructional Course Lectures, The American Academy of Orthopedic Surgeons*, Vol. 5:261-275. Ann Arbor, J. W. Edwards, 1948.
9. Nash, C. L. and Moe, J. H.: "A Study of Vertebral Rotation." *Journal of Bone and Joint Surgery*, Vol. 51-A:223-229, March, 1969.

## **Abstracts of Board Actions**

(Continued from page 10)

### **Assistance to IDPA**

Upon recommendation of the ISMS Executive Committee, ISMS has:

1. Offered IDPA the peer review services of ISMS. In so doing, ISMS indicated that--while its preferred method for solving physicians' problems with Medicaid is prior-to-payment review of physicians' bills under an ambulatory screening process through a contract with IFMC--the Society will do whatever is necessary to help clear up the department's backlog of post-payment problems.

2. Requested IDPA Director Trainor to provide ISMS with the names of those physicians on whom he wishes to have peer review conducted--urging him to refer suspected cases of illegal practices to the proper authorities for prosecution.

3. Agreed to employ a physician and whatever staff may be necessary to investigate and work up the cases for presentation to the appropriate county medical society peer review committee. The results of the county medical society review will be forwarded to ISMS, which will transmit them to IDPA. Referrals to county societies and IDPA will be handled administratively. If a local medical society review appears to be a variation from the preponderance of evidence, it will be referred to the ISMS Executive Committee. An appeal mechanism for the individual physician is provided for in the ISMS bylaws.

In a related action, the Board requested legal counsel to research the appropriateness of re-establishing the State Medical Advisory Committee as an ISMS committee, facilitating referral of physicians who are being investigated by IDPA to ethical relations committees.

### **Fiscal Audits**

Investigation of IDPA audit procedures, ordered last April by the House of Delegates, was reassigned from IFMC to the ISMS Governmental Health Care Reimbursement Committee. The Committee has reviewed IDPA's Handbook for Physicians and the Provider Agreement and submitted its comments to Director Trainor and the State Medical Advisory Committee to IDPA. The Board was informed that Society representatives had met recently with Director Trainor to present ISMS recommendations on these matters.

### **HB 1080**

Upon recommendation of the Council on Mental Health and Addiction, ISMS will try to defeat HB 1080, in both its original and amended form during the November session of the General Assembly. As amended, this bill restricts payments only to fully-licensed physicians and clinical psychologists, requires insurance carriers to offer optional mental health benefits to group policy holders only, and includes co-insurance features.

### **When Life Begins**

A new questionnaire to determine when doctors think life begins will be published in the Illinois Medical Journal. Members will be urged through Action Report to participate in this survey which was requested by the House of Delegates.

### **Task Force on Professional Liability**

The Task Force on Professional Liability has:

(A) Reaffirmed its opposition to compensation methods which do not relate to proof of negligence;

(B) Endorsed the concept of risk management as an effective method of dealing with potential suits;

(C) Urged ISMS to evaluate the Risk and Insurance Management Society (RIMS) program and share its findings with the Task Force;

(D) Agreed to support HB 3545, but urged further study of the bill which contains nearly every tort reform ISMS has considered, including a 2-year statute of limitations and contingency fee restrictions.

(E) Authorized a physician survey to assess the impact of the malpractice dilemma on cost and availability of care in Illinois;

(F) Launched a telephone information system designed to tell doctors how to avoid malpractice suits; and

(G) Authorized production of patient brochures, distribution of 1977 Malpractice Update Packet to the press, development of two slide presentations—one for physicians and one for the public—and packets for county medical societies to suggest how they can assist the Task Force in its efforts.

## **Relative Value**

ISMS will publicize the federal government's inconsistent views on Relative Value Studies. Despite the Justice Department's restraint of trade action against the American Society of Anesthesiologists for publishing such a scale, the U.S. Public Health Service places top priority on "developing and testing RVS as a basis for rate determination and capitation payment arrangements" in its "Forward Plan for Health."

## **Legislation**

ISMS will:

A. Attempt to modify SB 947 by requiring dispensers of medical services to disclose only direct ownership in health care facilities and not require the dispenser to reveal or identify his or her net worth, the nature and extent of the direct ownership interest in the facility.

B. Utilize the following definition of "Emergency Department" if the legislative need arises: "An Emergency Department is defined to mean an organized medical care team or medical personnel and that area of the hospital designated to provide immediate medical care for any person with an acute medical condition or injury where the same is liable to cause severe injury or serious illness or death. Emergency departments are not designed, staffed or equipped to provide continuing medical care."

C. Oppose the proposed Pharmacy Practice Act (HB 3950) in its present form and authorized a meeting with representatives of the Illinois Pharmaceutical Association to resolve differences.

D. Support continuation of the current statutory law restricting the scope of advertising allowed under the Medical Practice Act.

E. Reintroduce legislation in the January session of the General Assembly to certify and regulate ambulance services.

## **Confidentiality of Medical Records**

The Board rejected an AMA model bill on confidentiality and directed legal council to assist the Medical Legal Council in drafting another legislative proposal.

## **Physician's Assistants**

Acting on a report of the Advisory Committee to Physician's Assistants, the Board adopted the following position:

The purpose and objective of the physician's assistant concept is to provide a "physician extender" for those areas of medical practice where the physician in private practice (or community health facility) is in

need of assistance in delivering medical care to his patients.

It is the direction of the Board of Trustees that proposals to apply this concept to hospital employment of physician's assistants—or employment by hospital based (associated) physicians—be opposed.

The "supervising physician" should be the "employer physician." Whereas, it has been the intent from the beginning that this would be the only relationship between physician and P.A., any separation of the two be opposed.

The Board supports the upgrading of qualifications of P.A. to Class A by appropriate stages (availability, need, etc.), but opposes vague widening of the "exercise of independent judgment."

The Council on Education and Manpower and its advisory committee were requested to present specific recommendations in accordance with the Board's policy as stated.

### **Authorized Personnel in Operating Room**

The Board referred to the Council on Environmental and Community Health a recommendation that ISMS adopt the policy that licensing bodies be the final determinant of who should be present in hospital operating rooms as a protection for the patient.

### **Treating Alcoholics**

An educational program to assist physicians in meeting requirements of the new Alcoholism Treatment Act will be developed with the Chicago Hospital Council and Illinois Hospital Association for presentation during the ISMS annual meeting. In a related action, the Council on Mental Health was authorized to cooperate with the Illinois Department of Mental Health in preparing and distributing educational materials about alcoholism services.

### **Helicopter Agreement**

ISMS will urge the Illinois Department of Public Health to finalize an agreement for use of Coast Guard helicopters in the Illinois Emergency Medical System.

### **Parity of Psychologists**

The Board endorsed a resolution developed by the Council of Mental Health and Addiction requesting AMA to oppose hospital staff membership by psychologists. The resolution will be forwarded to the Illinois delegation to the AMA for introduction at the June meeting of AMA.



## *Doctor — Your Opinion Please*

Nearly a year ago, in response to Resolution 75M-35 (1975 Annual Meeting), a survey question was posed to the membership via this *IMJ* opinion page. The resolution called upon ISMS to "identify the Illinois doctors' views on when life begins." After thorough consideration, the Board of Trustees has indicated that the previous results were invalid due to receipt of multiple copies of responses returned by outside organizations.

Thus, the questions are again presented below. Please note that the tabulation of returns will include only those opinions *recorded on this actual page*, or a personal letter on the member's stationary. For statistical validity, xerox or other electrostatic copies, even if signed, will be excluded.

You are requested to complete the following brief survey and return it to:

Illinois State Medical Society  
Medical Legal Council  
55 E. Monroe Street  
Suite 3510  
Chicago, Illinois 60603

As a practicing physician, what is your medical opinion as to when life begins?

---

---

---

---

Do you think there should be a difference between medical and legal definitions as to when life begins?

☐ Yes

☐ No

Signature (Optional) \_\_\_\_\_

County Medical Society \_\_\_\_\_  
(please indicate)

# Adolescent Solvent Abuse

BY WILLIAM E. THORNTON, M.D./CHICAGO

The intentional inhalation of volatile substances has the potential for producing serious behavioral effects depending upon 1) the intensity of exposure, 2) user and peer expectations, 3) situational circumstances, and 4) the pre-morbid psychological state of the individual. The abusers of inhalant substances tend to represent a more homogenous group than abusers of other drugs.<sup>1</sup> They are often underprivileged boys between 10 and 17 years of age who are observed as being shy, insecure, and poor achievers.

These adolescents may prefer inhalant abuse for reasons which are not obvious to health care professionals. Inhalant substances are the least expensive and the most readily available of all intoxicants. They are found in most homes, schools, garages, and a variety of stores. In addition to the attraction of their negligible cost and easy accessibility, the abuser is likely to be reassured by the knowledge that the possession of these substances is not against the law. Generally, those who try these intoxicants will select an agent which is popular within his community, and after using it a few times will stop. A portion will continue on a daily basis, sometimes for several years.



WILLIAM E. THORNTON, M.D., is assistant professor of psychiatry at the University of Illinois Medical Center, Abraham Lincoln School of Medicine. He is the Chief of the Emergency Psychiatric Services and the Consultation-Liaison Psychiatrist to Primary Care and Ambulatory Medicine, as well as the Psychopharmacology Consultant to the Psychiatric In-Patient Service of the University of Illinois Hospital. Dr.

Thornton is also a member of the board of directors of the Chicago Treatment Alternatives to Street Crime (U.S. Law Enforcement Assistance Administration and Illinois Law Enforcement Commission). In addition, he is the president of the board of directors for Substance Abuse Services, Inc., in Chicago.

The prevalence of adult inhalant abuse is felt to be small. Incarcerated populations and employees in factories where intoxicating substances are frequently available would likely represent adult groups with susceptibility.

Traditionally, inhalant substances which are used to alter mental states are divided into three basic classes: 1) the commercial volatile solvents, 2) the aerosols, and 3) the anesthetic agents. Examples of products which are most commonly inhaled and their pharmacologically active constituents are listed by class in Table 1. Many of these active constituents were previously believed to be physiologically inert. However, literature suggesting their health hazards and cytotoxicity has accumulated during the past five years.<sup>2-8</sup> The most common route of administration includes dispensing the substance into a plastic or paper bag, which is then held over the nose and/or mouth where inhalation results in rapid absorption. An alternate method of administration involves breathing through a rag or gauze which is soaked with solvents or aerosols.

## General Symptoms

The voluntary inhalation of chemical substances for the purpose of mood alteration results in clinical effects ranging from mild inebriation resembling alcohol intoxication to frank delirium. A mental confusion with psychomotor agitation, grandiosity, emotional lability, and thought disorder are common manifestations. Early symptoms consist of slurred speech, dizziness, unsteady gait, impulsivity, excitement and irritability. Violent behavior associated with the impulsive irritability is quite possible, since the initial effects of these agents are similar to alcohol in that they extinguish control over behavior before motor activity is extinguished.<sup>1</sup> An invincible euphoric "high" is generally sought by the individual; drowsiness and sleep are common endpoints. Characteristic of delirium states is the likelihood of illusions, hallucinations, delusions, and panic.<sup>9-11</sup> Physician consultation and treat-

**TABLE 1****Commonly Abused Inhalants and Their Pharmacologically Active Constituents****Volatile Solvents**

Household Cements: acetone, toluene, methyl ethyl ketone, methyl isobutyl ketone

Model-Plastic Cements: toluene, acetone naphtha, n-hexane, trichloroethylene, cyclohexane, aliphatic acetates

Rubber Cements: hexane, trichloroethylene, benzene

Lacquer Thinners: toluene, aliphatic acetates

Lighter Fluids: naphtha

Fingernail Polish Removers: acetone, benzene, aliphatic acetates

Cleaning Fluids: trichloroethane, trichloroethylene, carbon tetrachloride, naphtha, perchlorethylene

Petroleum Products: toluene, naphtha, n-hexane, benzene

**Anesthetics**

Nitrous Oxide, Ether, Trichloroethylene, Chloroform

**Aerosols**

Hair Sprays, Deodorants, Glass Chillers, Vegetable Frying Pan Lubricants: Florocarbons or Chlorinated hydrocarbons (propellants), eg., freons, trichloroethane, trichloroethylene, perchloroethylene

ment advice is usually sought for the management of the acute behavioral and toxic manifestations of inhalant usage. Knowledge of chronic mental, physiological, and environmental sequelae, however, is imperative for comprehensive medical management.

The effects of chronic inhalant use are characterized by the development of tolerance and profound habituation. Definite tolerance has been reported for toluene and naphtha.<sup>12,13</sup> The expectation is that other inhalant substances will also produce tolerance, depending on the frequency and intensity of substance exposure. The existence of physical dependence and a resultant abstinence syndrome upon withdrawal from the substance is unlikely. However, withdrawal from chronic, excessive inhalant use is accompanied by lethargy, restlessness, irritability, depression and drug seeking behavior. The intensity of drug seeking behavior combined with a tendency for an unusually high degree of commitment to the specific inhalant agent being abused results in high recidivism rates and discouraging treatment relationships. It is imperative that the physician appreciates the degree of habituation and the fact that the compulsion to abuse inhalants may equal or exceed that seen with most other forms of drug abuse.

**Physiological Hazards**

The acute physiological hazards of inhalant

abuse are unquestionably real and are reflected in the literature by reports of sudden deaths.<sup>14-16</sup> The interactions of organ system injury and accident-prone behavior account for the majority of deaths. The concomitant occurrence of drug induced physical excitement and cardiac arrhythmia, or drug induced pulmonary-alveolar occlusion accompanied by plastic bag suffocation, are examples of the kind of interactions which yield lethal results. The pathophysiological consequences of inhalant abuse are multiple and varied. Aplastic anemia, permanent encephalopathy, cardiac arrhythmia, polyneuropathy, disturbance of liver function, hepatorenal injury, and cerebellar degeneration are among the many reported physical sequelae.<sup>16-22</sup> The question of irreversible central nervous system impairment has not been resolved; however, the existent case reports represent sufficient cause for alarm.<sup>22</sup> Toxicity of aerosol propellants in the respiratory and cardiovascular systems has been studied and classified by Aviado.<sup>2-7</sup>

**Methods of Treatment**

The diagnosis of inhalant induced intoxication is made by history, observation of symptomatology, and often, by the detection of an odor which is characteristic of the abused substance. Management consists of observation with special attention to preventing the patient from hurting himself and others. Around-the-clock accompani-

ment by a drug abuse volunteer in a residential treatment setting is an ideal means of management. The similar use of family, friends or skilled nursing personnel may be employed. The use of sedatives and tranquilizers should be guarded, since further clouding of consciousness may aggravate the patient's reaction to his confusion and disorientation. Additionally, the use of phenothiazines should be avoided because of their known potential to induce cardiac arrhythmias.

Physician guidelines for long term treatment are centered around the importance of influencing the patient's self-image and attracting his interests away from undesirable peer influence.<sup>23</sup> Such efforts will likely require treatment assistance from family, school, friends, and community drug abuse personnel.<sup>16</sup> If local support and treatment fails to influence the patient's inhalant abuse, the physician should explore the regional availability of a residential therapeutic community for the treatment of adolescent drug abusers. This latter treatment modality frequently offers benefits to the demoralized inhalant abuser who so often has special problems with poor self-confidence and insecurity. ◀

#### References

- Cohen, S., "Glue Sniffing," *J.A.M.A.* 231:653-654, 1975.
- Aviado, D. M., "Toxicity of Aerosols," *J. Clin. Pharmacol.* 15 (1):86-104, 1975.
- Taylor, G. J., and Harris, W. S., "Cardiac Toxicity of Aerosol Propellants," *J.A.M.A.* 214:81-85, 1970.
- Speizer, F. E., Wegman, D. H., and Ramirex, A., "Pulmonary Rates Associated with Fluorocarbon Exposure in a Hospital Study," *New Engl. J. Med.* 292 (12):624-626, 1975.
- Schmidt, A. M., "Trichloroethane," *Fed. Reg.* 28: 21935, 1973.
- Belej, M. A. and Aviado, D. M., "Cardiopulmonary Toxicity of Propellants for Aerosols," *J. Clin. Pharmacol.* 15:105-115, 1975.
- Aviado, D. M. and Drimal, J., "Five Fluorocarbons for Administration of Aerosol Bronchodilators," *J. Clin. Pharmacol.* 15:116-128, 1975.
- Aviado, D. M., "Toxicity of Propellants" in *PROGRESS IN DRUG RESEARCH*, Edited by Jucker, E., Basel, Birkhauser Verlag, 1974. pp. 365-398.
- Glaser, F. B., "Inhalation Psychosis and Related States," *Arch. Gen. Psychiat.* 14:315-322, 1966.
- Panse, F. and Bender, W., "Toxic Psychosis from Toluene," *Psychiatria et Neurologia*, 89:249, 1954.
- Tolan, E. J. and Lingl, F. A., "Model Psychosis Produced by Inhalation of Gasoline Fumes," *Amer. J. Psychiat.* 120:757-761, 1964.
- Satran, R. and Dobson, V. N., "Toluene Habituation: Report of a Case," *New Engl. J. Med.* 268:719-721, 1963.
- Merry, J. and Zachariadis, N., "Addiction to Glue Sniffing," *Brit. Med. J.* 2:1148, 1962.
- Bass, M., "Sudden Sniffing Death," *J.A.M.A.* 212:2075-2079, 1970.
- Muslow, C. E. and Awen, C. F., "Glue Sniffing: Report of a Fatal Case," *Can. Med. Assoc. J.* 104:315-317, 1971.
- Press, E. and Done, A. K., "Solvent Sniffing. Physiological Effects and Community Control Measures for Intoxication from the Intentional Inhalation of Organic Solvents," *Pediatrics* 39:451-461, 611-622, 1967.
- Prockop, L., Huffers "Neuropathy," *J.A.M.A.* 229: 1083-1085, 1974.
- Grabski, D. A., "Toluene Sniffing Producing Cerebellar Degeneration," *Amer. J. Psychiat.* 118:461-462, 1961.
- Powers, D., "Aplastic Anemia Secondary to Glue Sniffing," *New Engl. J. Med.* 273:700-702, 1965.
- Baerg, R. D. and Kimbert, D. V., "Centrilobular Hepatic Necrosis and Acute Renal Failure in Solvent Sniffers," *Ann. Int. Med.* 73:713-716, 1970.
- Flowers, N. C. and Horan, L. G., "Nanoxenic Aerosol Arrhythmias," *J.A.M.A.* 219:33-37, 1972.
- Knox, J. W. and Nelson, J. R., "Permanent Encephalopathy from Toluene Inhalation," *New Engl. J. Med.* 275:1494-1496, 1966.
- Rubin, T., "Glue Sniffing: A Rehabilitation Approach" in *Resource Book for Drug Abuse Information*, Rockville, Md., National Clearinghouse for Mental Health Information, 1969.

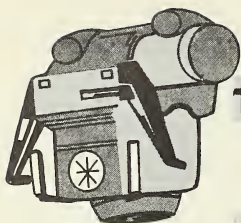
## Clinic Medical Director

Position for PART TIME Medical Director for General Practice Clinic at Ravenswood Hospital Medical Center, Chicago. Responsible for the providing of direct care to clinic patients and for the supervision of the resident physician assigned to Clinic.

Excellent salary and benefit program. Write for confidential interview:

Selection Committee  
General Practice Clinic  
c/o Vice President, Administration  
**rh** Ravenswood Hospital  
Medical Center  
4550 N. Winchester  
Chicago, Ill. 60640  
*An Equal Opportunity Employer*





## the view box

LEON LOVE, M.D./CHAIRMAN/DEPARTMENT OF RADIOLOGY  
LOYOLA UNIVERSITY STRITCH SCHOOL OF MEDICINE

# Pancreatic Pseudocyst

BY ROBERT CHURCHILL, M.D. AND CARLOS J. REYNES, M.D.  
DEPARTMENT OF RADIOLOGY, DIVISION OF DIAGNOSTIC IMAGING  
LOYOLA UNIVERSITY MEDICAL CENTER, MAYWOOD, ILLINOIS

**CASE HISTORY:** Sixty-seven year old female presented with epigastric pain and a palpable mass. She had a severe episode of abdominal pain that radiated to the back four weeks prior to this admission.

The ultrasound and CAT whole body scan are presented (Figures 1 and 2).

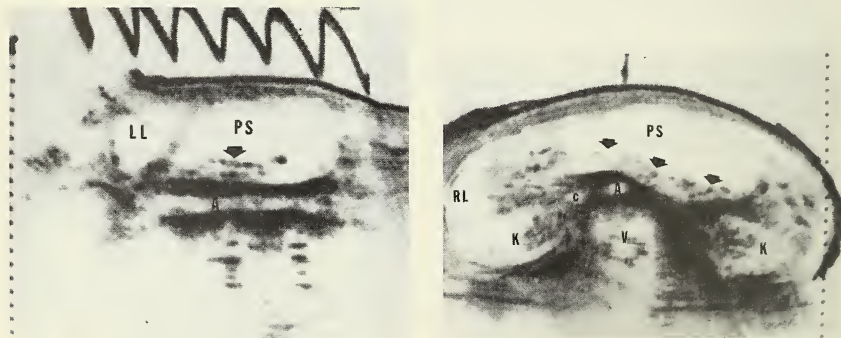


Figure 1

Longitudinal and transverse ultrasonograms showing a large unilocular, sonolucent mass with echo producing debris (arrow) along the dependent, posterior wall. (PS-pseudocyst, A-aorta, C-cava, LL-left lobe of the liver, RL-right lobe of the liver, K-kidney, V-vertebra.)

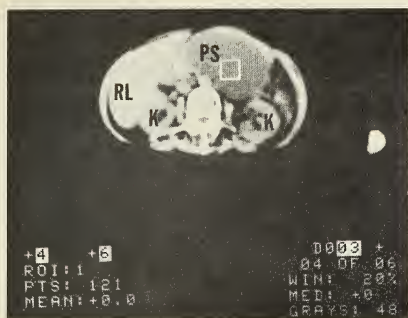


Figure 2

Whole body CAT scan showing a large water density mass in the upper abdomen. (PS-pseudocyst, RL-right lobe of the liver, K-kidney). The area within the white square has a density reading of zero (water density).

The majority of pancreatic pseudocysts (75%) occur secondary to acute or chronic pancreatitis, however approximately 20-25% result from blunt or surgical trauma. Only a small percentage seemingly have no demonstrable cause.<sup>1</sup>

Plain x-ray film findings may include adynamic ileus, soft tissue mass density, displacement of adjacent gas-containing organs, displacement of the left kidney, and a left sided pleural effusion.

Upper gastrointestinal barium studies may show anterior displacement of the stomach and duodenum in 80-85% of the cases.<sup>1</sup> Retroperitoneal tumors that have not yet invaded these structures cannot be excluded radiographically.

Ultrasound should be the first procedure of choice for the diagnosis of pseudocysts. The rare occurrence of a true pancreatic cyst cannot be distinguished from a pseudocyst. We have seen one such case in the past three years. The typical finding of a pseudocyst with ultrasound is a smooth walled, unilocular, sonoluent mass in the area of the pancreas.<sup>2</sup> The walls can be irregular and the cyst may contain echo producing debris in its dependent portion. When a lot of debris is present differentiation from an abscess cannot be made echographically. Ultrasound is a simple method of following pseudocysts. They may spon-

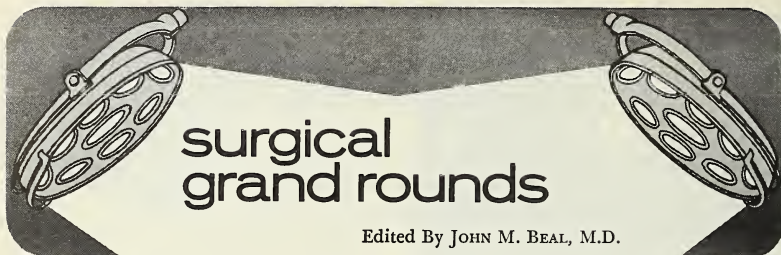
taneously disappear during the course of follow-up.<sup>3</sup>

Recently computer assisted tomographic (CAT) whole body scanning has been added to the armamentarium of non-invasive radiographic procedures at Loyola University Medical Center. It is particularly useful in patients where excessive bowel gas prevents successful visualization with ultrasound, and also in obese patients in whom the degree of sound attenuation is great enough to limit diagnostic accuracy. The advent of the fast scanners (5 sec.) utilizing a 360 degree rotational fan beam (Searle Pho/trax 4000) has reduced patient radiation exposure and virtually eliminated motion artifact. This is particularly true in severely ill patients who cannot hold their breath for more than a few seconds. The ability to determine the relative densities of materials based on the linear X-ray attenuation coefficients can be used to accurately discriminate solid from cystic lesions.<sup>4,5</sup> Dilute water soluble contrast material by mouth is routinely employed to opacify the stomach, duodenum, and proximal small bowel loops to more clearly separate the pancreas from these structures.<sup>4,5</sup>

As is true with ultrasound, whole body CAT scanning should not be utilized as a screening procedure in most instances. Each exam should be specifically tailored for each clinical situation through prior consultation with the physician in charge of diagnostic imaging.

## References

1. Eaton, S. B., Ferruci, J. T.: *RADIOLOGY OF THE PANCREAS AND DUODENUM*, Saunders, Philadelphia, 1973, 253-254, 365-369.
2. Doust, B. D.: "Ultrasonic Examination of the Pancreas," *Radiol Clinics of N. Am.* 13:467-478, December 1, 1975.
3. Doust, B. D., Pearce, J. D.: "Gray-Scale Ultrasonic Properties of the Normal and Inflamed Pancreas," *Radiology* 120:653-657, September, 1976.
4. Sheedy, P. F., Stephens, D. H., Hattery, R. R., Muhm, J. R., Hartment, G. W.: "Computed Tomography of the Body: Initial Trial with the EMI Prototype," *Am. J. Roentgenol.* 127:23-51, July, 1976.
5. Stanley, R. J., Sagel, S. S., Levitt, R. G.: "Computed Tomography of the Body: Early Trends in Application and Accuracy of the Method," *Am. J. Roentgenol.* 127: 53-67, July, 1976.



*Surgical Grand Rounds are held weekly on Tuesday at 5:00 p.m. in the Offield Auditorium of the Passavant Pavilion, Northwestern Memorial Hospital. Patient presentations from Northwestern Memorial Hospital and the Veterans Administration Lakeside Hospital form the basis of the discussions. This case report was part of the Surgical Grand Rounds of July 20, 1976.*

## Case Report: Liver Tumor

**Dr. James Shull:** A 40-year-old white woman was admitted to the hospital for an elective cholecystectomy. The patient reported a four-month history of epigastric discomfort and nausea, associated with the ingestion of fatty meals. Several small gallstones were demonstrated by oral cholecystography. She denied fever, chills, or jaundice. Her past medical history was unremarkable, without previous operations of major medical illnesses. She reported that she had been taking "birth-control" pills for 14 years, but no other medication. A history of drinking or smoking was not present. Physical examination revealed mild right upper quadrant tenderness, but without palpable masses or organomegaly. Routine laboratory studies were within normal limits. Chest X-ray and electrocardiogram were negative.

The patient was taken to the operating room the day after admission. During exploration, a tumor was found in the right lobe of the liver just above the gallbladder, which was yellow, firm and not cystic. Following cholecystectomy and normal operative cholangiography, the tumor was resected.

**Dr. Hector Battifora:** Grossly, this was a sharply demarcated tumor made up of tissue of

light tan color and semi-firm consistency. The presence of a white star-shaped central scar in the middle of the tumor was quite obvious.

The gross appearance was diagnostic of nodular hyperplasia (hamartoma) of the liver, since hepatic adenomas usually lack this central scar. The differential diagnosis with adenoma and well differentiated adenocarcinoma of the liver was made easy by the presence of bile ducts within the tumor. Adenomas and carcinomas are made up exclusively of hepatocytes. Because histologic sections of this tumor resemble liver cirrhosis, the term "focal cirrhosis" has been employed to designate this lesion.

**Dr. James Shull:** Liver cell adenoma has been considered to be uncommon. The Mayo Clinic series of benign liver tumors from 1904 to 1954 recorded only four cases of liver cell adenoma. Most of their benign liver tumors were hemangiomas and non-parasitic cysts. **However, since 1960, there has been an increasing number of liver cell adenomas reported in women who have been taking birth control pills, particularly those containing the synthetic estrogen Mestranol.** A recent series by Doctor Edmondson of the University of California, recorded 42 women that had liver cell

adenomas from 1955 to the present. He interviewed these women regarding the use of oral contraceptives, the duration of use, their age at the time of their first pregnancy, age of menarche, and other drug history. Each woman was asked to supply the name of a neighbor within three years of her age to serve as a control group. These women were also interviewed in a similar manner. Four major categories were defined. Eighteen women presented with a right upper quadrant mass and ten had used oral contraceptives. A second group complained of pain in the right upper quadrant, usually described as sharp, localized and persisting from one hour to three weeks. Of the 12 women who presented with primarily pain, seven had fresh infarction in their tumors. The third and most serious group included women who developed shock from intraabdominal bleeding, due to rupture of these liver cell adenomas. Of the ten women presenting in shock, seven were actively menstruating at the time of rupture of the tumor, a statistically highly significant finding. A fourth group consisted of asymptomatic tumors, as in this case. There were two cases, one found at elective cholecystectomy and the other by liver scan.

The average duration of use of oral contraceptives in women with liver cell adenomas was 79 months and in controls, it was only 39 months. **Thus, there appears to be a significantly increased risk after 60 months of use.** Birth control pills contain one of two synthetic estrogens, either Mestranol or Ethinyl Estradiol. Ninety-three percent of women with liver cell adenomas were taking pills containing Mestranol, while only 30 percent of the controls were taking pills containing Mestranol. **Therefore, two major risk factors appear to be present in the development of liver cell adenoma. The first is the duration of the use of oral contraceptives and the second is the type of synthetic estrogen.**

Mestranol is converted in the liver to Ethinyl Estradiol by a demethylation process. Mestranol has a methyl group at C13 which the liver breaks to form Ethinyl Estradiol. In animal studies, it has been shown that both compounds result in cholestasis. In other reported series, women with liver cell adenomas have received only Ethinyl Estradiol; thus, either type of pill can cause liver cell adenoma.

The association between rupture of liver cell adenomas and menstruation appears, in theory, to be on the basis that the artery which supplies the adenoma constricts at the same time that

the spiral arterials constrict in the endometrium, causing sloughing and bleeding.

**Any woman taking birth control pills for more than five years should have her liver palpated at each physical examination and should be examined at six month intervals.**

**Dr. James Hines:** There were at least two deaths due to these ruptures in a series of some 20 cases. Therefore, it can be a cause of death in these patients, rather than just an incidental finding.

**Dr. Stuart Poticha:** The two most common benign liver tumors are hemangiomas and hamartomas. In the past, these tumors were resected only if they were readily accessible and could be removed with a wedge resection, or if they were extremely large. Rapid growth and spontaneous rupture seldom occurred. Hepatic adenomas, on the other hand, tend to grow and can rupture, causing massive hemorrhage. The problem for the surgeon, when confronted with an unsuspected liver tumor, is first to rule out hemangioma. These tumors are bluish in color and soft in consistency. They should not be biopsied unless they can be removed completely with a wedge resection. If the tumor does not appear to be a hemangioma, it should be biopsied, since hepatic adenomas cannot be diagnosed on gross examination. If the biopsy reveals a benign adenoma, the tumor should be resected. When these tumors are left untreated, about 25% will grow to the point of rupture and sudden massive hemorrhage. This tumor resembled a metastatic carcinoma. A needle biopsy revealed normal liver tissue, which was interpreted as hepatic adenoma. This diagnosis precipitated the resection of the liver mass.

**Dr. Hector Battifora:** This is the sampling problem which is prone to occur, particularly with needle biopsy. You really have to find an entire portal field and these are few and far between. Even a wedge biopsy, if not deep enough, may not eliminate this problem.

**Dr. James Hines:** Dr. Gerbie from the Department of Gynecology is here. You and your colleagues frequently prescribe these contraceptive pills. Do you have any information concerning the frequency of liver adenoma among your patients?

**Dr. Melvin Gerbie:** This is the first patient that I've heard of from this medical center with liver abnormality due to the pills or in a patient who is taking the pill. We expect to see more of these. I think the figures given are interesting when you try and read a medical arti-



cle. Ortho-Novum® is probably, along with Valium, the most frequently prescribed prescription drug in the world. Ortho-Novum® contains Mestranol. Enovid®, which was the pill with the capital P when it was invented, used Mestranol. Norinyl® is the Syntex product— Syntex makes a pill that they sell to a division of theirs as Norinyl® and they sell another pill to the Ortho company, which they market as Ortho-Novum.® **So, the vast majority of women taking birth control pills are taking a Mestranol product.** Secondly, as far as the length of time is concerned, I have found clinically, strictly anecdotal, that most of our patients who are on other pills have breakthrough bleeding. We then change to a Mestranol containing drug which they take for a longer period of time because they work better for that patient.

This is the time to start examining the abdomen in a patient that is being seen for routine check-up, an important point that we have recommended before. Patients who are taking steroids or other potent medications and are in a doctor's office should have their blood pressure taken, and both breasts and abdomen examined. Many times the gynecologist or the family physician is the only doctor seeing the patient who is receiving contraceptive medication. Palpation of the liver should be included in routine visits related to such medication.

#### References

McAvoy, J. M., Tompkins, R. K. and Longmire, W. P. Jr.: "Benign Hepatic Tumors and Their Association With Oral Contraceptives." *Arch. Surg.* 111, 761, 1976.

## PRE-REGISTER NOW **MEDICLINICS**

Postgraduate Medical Refresher Course

**MARCH 7-18, 1977**

**Fort Lauderdale, Florida**

Headquarters: Galt Ocean Mile Hotel

**Sponsored by Florida Academy of Family Practice and the Broward Medical Center**

**50**  
**CATEGORY 1 CREDITS**

Registration information: **MEDICLINICS**

832 Central Medical Building  
Saint Paul, Minnesota 55104

All types hotels and motels available  
**TWO FULL WEEKS**

**Registration Fee: \$300.00**

## Clinics for Crippled Children Listed for February

Thirty-three clinics for Illinois physically handicapped children have been scheduled for February by the University of Illinois, Division of Services for Crippled Children. The Division will count 23 general clinics providing diagnostic orthopedic, pediatric, speech and hearing examination along with medical, social and nursing services. There will be eight special clinics for children with cardiac conditions and two for children with cerebral palsy. Any private physician may refer to or bring to a convenient clinic any child or children for whom he may want examination or consultative services.

- February 1 E. St Louis, Christian Welfare Hospital
- February 2 Aurora, St. Joseph's Mercy Hospital
- February 2 Hinsdale, Hinsdale Sanitarium
- February 3 Lake County Cardiac, Victory Memorial Hospital
- February 4 Division Cardiac, U. of I at the Medical Center
- February 8 Peoria, St. Francis Hospital
- February 9 Champaign-Urbana, McKinley Hospital
- February 9 Joliet, St. Joseph's Hospital
- February 10 Sterling, Community General Hospital
- February 10 Springfield, St. John's Hospital
- February 10 Flora, Clay County Hospital
- February 10 Kankakee, St. Mary's Hospital
- February 11 Chicago Heights Cardiac, St. James Hospital
- February 14 Peoria Cardiac, St. Francis Hospital
- February 14 Maywood, Loyola Medical Center
- February 15 E. St Louis, Christian Welfare Hospital
- February 15 Rock Island, Moline Public Hospital
- February 16 Springfield Pediatric-Neurology, St. John's Hospital
- February 16 Chicago Heights General, St. James Hospital

- February 17 Rockford, St. Anthony's Hospital
- February 17 DuQuoin, Marshall Browning Hospital
- February 17 Bloomington, Mennonite Hospital
- February 17 Elmhurst Cardiac, Memorial Hospital of DuPage County
- February 22 Belleville, St. Elizabeth's Hospital
- February 22 Peoria, St. Francis Hospital
- February 22 Danville, Lake View Hospital
- February 22 Park Ridge Cardiac, Lutheran General Hospital
- February 23 Anna, Union County Hospital
- February 23 Rock Island Cerebral Palsy, Foundation for Crippled Children and Adults
- February 23 Jacksonville, Norris Hospital
- February 25 Evanston, St. Francis Hospital
- February 25 Chicago Heights Cardiac, St. James Hospital
- February 28 Peoria Cardiac, St. Francis Hosp.

The Division of Services for Crippled Children is the official state agency established to provide medical, surgical, corrective and other services and facilities for diagnosis, hospitalization and after-care for children with crippling conditions or who are suffering from conditions that may lead to crippling. In carrying on its program, the Division works cooperatively with local medical societies, hospitals, the Illinois Children's Hospital-School, civic and fraternal clubs, visiting nurse association, local social and welfare agencies, local chapters of the National Foundation and other interested groups. In all cases the work of the Division is intended to extend and supplement, not supplant, activities of other agencies, either public or private, state or local, carried on behalf of crippled children.

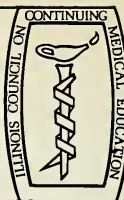
## *Enzymes for Phlebitis*

From September, 1962, to May, 1972, 145 patients with acute or subacute deep vein thrombosis confirmed by phlebography were treated with streptokinase. During the same period 42 patients considered unfit for thrombolytic therapy were treated with heparin and oral anticoagulants. The results, assessed by repeat phlebography, in 93 of the patients treated with streptokinase were compared with those in the 42 patients treated with heparin. The age, sex, and severity of occlusion were roughly similar in both groups. Streptokinase treatment was successful in 42%, partially successful in 25%, and unsuccessful in 32% of the 93 patients compared with none, 10%, and 88% respectively in the 42 patients treated with heparin.

Streptokinase was more effective when the thrombus was in proximal rather than calf veins. Thrombi of more than six days were readily lysed. Plasma fibrinogen levels were below 0.8 g/l (80 mg./100 ml) in nearly all patients successfully treated. The incidence of pulmonary embolism was no greater with streptokinase than with heparin treatment. Only prolonged follow-up would show whether thrombolytic treatment would be effective in preventing the late complications of deep vein thrombosis such as chronic venous insufficiency. (F. Duckert et al.: "Treatment of Deep Vein Thrombosis with Streptokinase." *British Med. J.* (Mar 1) 1975, pgs. 479-481.)

# ISMS Guide to Continuing Medical Education

Compiled for Illinois physicians by the  
ILLINOIS COUNCIL ON CONTINUING MEDICAL EDUCATION  
55 E. Monroe St., Suite 3510 • Chicago, IL 60603 • (312) 236-6110



Items for this Calendar must be received 90 days prior to the event. Those received earlier may appear in up to three monthly issues.

**WARNING!** Items for this Calendar come from many sources, often far in advance of the publication date. Sometimes, cancellations or changes in date, place or time occur too late to be corrected before publication. You are urged to contact the sponsoring organization to confirm information given below.

## FEBRUARY

### Cancer

#### FOURTH ANNUAL CHICAGO SYMPOSIUM— IMMUNOTHERAPY OF SOLID TUMORS

For: Oncologists, Surgeons, Internists, Hematologists. Symposium, February 24 and 25, 9:00 AM-5:00 PM daily (followed by dinner). Pick-Congress Hotel, Chicago. Speaker: Stephen Carter, Director, Northern California Cancer Center. CME Credit: 13 hrs. AMA Cat. 2, Fee: \$60. Reg. Deadline: February 23. Reg. Limit: 250. Sponsor, contact: ITR Biomedical Research of the University of Illinois at the Medical Center, 115 S. Sangamon St., Chicago, IL 60607. Attn: Nancy Plekarski, Conference Coordinator. Telephone: (312) 996-4588. Co-sponsors: Illinois Cancer Council and American Cancer Society.

### Emergency Medicine

#### EMERGENCY MEDICINE

For: Emergency physicians. 5-day workshop and lectures. February 21-25. University of Michigan Medical Center, Ann Arbor, MI. CME Credit: AMA Cat. 1; AAP Elective; AOA. Fee: To be determined. Sponsor, contact: Office of Continuing Education, Dept. of PGM/HPE, Towsley Center, University of Michigan Medical Center, Ann Arbor, MI 48109. Attn: Bette Anderson. Telephone: (313) 763-8100. Co-sponsor: Michigan Chapter, American College of Emergency Physicians.

### Family Medicine

#### DECISION MAKING IN EMERGENCY MEDICINE

For: Physicians. Lecture. February 15, 8:00 PM. Assembly Hall, Sherman Hospital, Elgin. Speaker: Peter Rosen, M.D., Director, Division of Emergency Medicine and Director, Emergency Residency Program, University of Chicago. CME Credit: 2 hrs. AMA Cat. 1. Fee: None. Sponsor, contact: Continuing Medical Education Committee, Sherman Hospital, 934 Center Street, Elgin, IL 60120. Attn: Mary Anne Slegemeier. Telephone: (312) 742-9800, ext. 649.

### Family Therapy

#### INTRODUCING FAMILY SYSTEMS (Introductory Course)

For: Physicians and Mental Health Professionals. One Week Course. 9:00 AM to 3:30 PM Daily Monday through Friday. The Family Institute of Chicago/Center for Family Studies, 10 E. Huron, Chicago. Speaker: Nancy Rosen, ACSW, Family & Mental Health Service of Southwest Cook County. CME Credit: 30 hrs. AMA Cat. 1. Fee: \$130. Reg. Limit: 24. Sponsor, contact: The Family Institute of Chicago/Center for Family Studies, 10 E. Huron, Chicago, IL 60611. Attn: Belinda M. Stone. Telephone: (312) 440-1414. Co-sponsors: Northwestern Memorial Hospital and Northwestern University Medical School.

#### ON BECOMING A FAMILY THERAPIST (Intermediate Course)

For: Physicians and Mental Health Professionals. One Week Course. 9:00 AM to 3:30 PM Monday through Friday. The Family Institute of Chicago/Center for Family Studies, 10 E. Huron, Chicago. Speaker: Jeanne Robinson, ACSW, The Family Institute of Chicago/Center for Family Studies, Northwestern Memorial Hospital and Northwestern University Medical School. CME Credit: 30 hrs. AMA Cat. 1. Fee: \$130. Reg. Limit: 24. Sponsor, contact: The Family Institute of Chicago/Center for Family Studies, 10 E. Huron, Chicago, IL 60611. Attn: Belinda M. Stone. Telephone: (312) 440-1414. Co-sponsors: Northwestern Memorial Hospital and Northwestern University Medical School.

#### THE PRACTICING FAMILY THERAPIST (Advanced Course)

For: Physicians and Mental Health Professionals. One Week Course. 9:00 AM-3:30 PM Monday through Friday. The Family Institute of Chicago/Center for Family Studies, 10 E. Huron, Chicago. Speaker: Robert Rutledge, ACSW, The Family Institute of Chicago/Center for Family Studies, Northwestern Memorial Hospital and Northwestern University Medical School. CME Credit: 40 hrs. AMA Cat. 1. Fee: \$130. Reg. Limit: 24. Sponsor, contact: The Family Institute of Chicago/Center for Family Studies, 10 E. Huron, Chicago, IL 60611. Attn: Belinda M. Stone. Telephone: (312) 440-1414. Co-sponsors: Northwestern Memorial Hospital & Northwestern Univ. Medical School.

#### ONGOING SEMINAR: THE THERAPIST'S OWN FAMILY

For: Physicians and Mental Health Professionals. Ongoing seminar (monthly Saturday morning workshop). Jan. 15, Feb. 19, March 26, April 23, June 4, 9:00 AM-1:00 PM daily. Oak Park. Speaker: Jeannette Kramer, The Family Institute of Chicago, NIMH and NUMS. CME Credit: 20 hrs. AMA Cat. 1. Fee: \$150. Reg. Limit: 8. Sponsor, contact: The Family Institute of Chicago/Center for Family Studies, 10 E. Huron, Chicago, IL 60611. Attn: Belinda M. Stone. Telephone: (312) 440-1414. Co-sponsors: Northwestern Memorial Hospital & Northwestern University Medical School.

### Medical Seminar

#### TWELFTH MEDICAL SEMINAR FOR LAKE COUNTY

For: Physicians, dentists, nurses, pharmacists. Seminar/Symposium. February 23, 9:00 AM-Noon. The Leonard Hall, St. Therese Hospital, Waukegan. Speakers: Dr. Herbert Topper, Dr. Tien Cheng (Internists at St. Therese Hospital); Dr. Carlos Puig and Dr. Rodney Haenschen (Emergency Service at St. Therese). CME Credit: 3 hrs. AMA Cat. 1; AAP Elective. Fee: None. Reg. Deadline: February 21. Sponsor, contact: St. Therese Hospital, 2615 Washington, Waukegan, IL 60085. Attn: R. M. Adelman, D.D.S., M.D. Telephone: (312) 688-5800.

### Musculoskeletal & General Surgery Trauma

#### MUSCULOSKELETAL & GENERAL SURGERY TRAUMA

For: All physicians. Clinical hospital program on Trauma. February 15, 8 PM-10 PM. Children's Memorial Hospital, Chicago. Speakers: To be announced. CME Credit: 2 hrs. AMA Cat. 1; AAP Elective. Fee: None. Sponsor, contact: Chicago Committee on Trauma of the American College of Surgeons, 11255 W. 74th St., LaGrange, IL 60525. Attn: Mrs. Lillian Huns. Telephone: (312) 246-3788 or 482-8686.

### Pediatrics

#### SPECIALTY REVIEW COURSE IN PEDIATRIC SURGERY

For: Surgeons (Prep. for Board). Lecture. Feb. 14 (5 days). Cook County Graduate School of Medicine, Chicago. Speaker: John Raffensperger, M.D. (Coordinator). CME Credit: 38 hrs. AMA Cat. 1. Fee: \$200. Reg. Limit: 150. Sponsor, contact: Cook County Graduate School of Medicine, 707 S. Wood St., Chicago, IL 60612. Attn: Robert J. Baker, M.D., Dean. Telephone: (312) 733-2800.

#### MARRIAGE WITHOUT WALLS

For: Professionals and Students in the Health Field. Lecture. Feb. 7, 7:30-9:30 PM. Forest Hospital Professional Center, Des Plaines. Speakers: Samuel James, Ph.D. and Barbara Bess, M.D. (Coordinators). York Medical College. CME Credit: 2 hrs. AMA Cat. 1. Fee: \$15 (prof.); \$5 (students). Reg. Limit: 100. Reg. Deadline: advance registration requested. Sponsor, contact: Forest Hospital Foundation, 555 Wilson Lane, Des Plaines, IL 60016. Attn: Leo Jacobs, M.D., Director of Medical Education. Telephone: (312) 827-8811.

### Psychiatry

#### THE MIND-BODY RELATIONSHIPS IN ILLNESS AND HEALING

For: Mental health care professionals. Lecture. Feb. 16, 1:00-4:00 PM. Riveredge Hospital, Forest Park. Speaker: Jerome D. Frank, M.D., Johns Hopkins U. School of Medicine, Baltimore. CME Credit: 3 hrs. AMA Cat. 1. Fee: \$10. Reg. Limit: 200. Reg. Deadline: Reservations 771-7000 ext. 305. Sponsor, contact: Riveredge Hospital Foundation, 8311 W. Roosevelt Road, Forest Park, IL 60130. Attn: John Pontarelli, Community Relations. Telephone: (312) 771-7000 ext. 305.

#### TECHNIQUES OF LEGISLATIVE INFLUENCE

For: Psychiatrists. Distinguished lecture series. Feb. 16, 8:00 PM. Offield Auditorium, Passavant Hospital, Chicago. Speaker: Robert J. Campbell, M.D., Chairman, APA Commission on Legislation. CME Credit: 1½ hrs. AMA Cat. 1. Fee: None. Sponsor: Institute of Psychiatry-Northwestern University Medical School. Contact: Institute of Psychiatry, 320 E. Huron, Chicago, IL 60611. Attn: Jeanne Smith. Telephone: (312) 649-8058.

### Surgery

#### REVIEW COURSE IN NEUROLOGICAL SURGERY

For: Neurological Surgeons. Lecture. Feb. 4 (10 days). Speaker: Leonard I. Krazmier, M.D. (Coordinator). CME Credit: 95 hrs. AMA Cat. 1. Fee: \$400. Reg. Limit: 200. Sponsor, contact: Cook County Graduate School of Medicine, 707 S. Wood Street, Chicago, IL 60612. Attn: Robert J. Baker, M.D., Dean. Telephone: (312) 733-2800.

#### SPECIALTY REVIEW COURSE IN THORACIC SURGERY

For: Surgeons. Lecture. Feb. 21 (5 days), Cook County Graduate School of Medicine, Chicago. Speaker: Constantine Taftoies, M.D. (Coordinator). CME Credit: 40 hrs. AMA Cat. 1. Fee: \$200. Reg. Limit: 200. Sponsor, contact: Cook County Graduate School of Medicine, 707 S. Wood St., Chicago, IL 60612. Attn: Robert J. Baker, M.D., Dean. Telephone: (312) 733-2800.

## MARCH

### Anesthesiology

#### EKG FOR ANESTHESIOLOGISTS

For: Anesthesiologists. Lecture and equipment demonstration. March 21 (for 5 days), Cook County Graduate School of Medicine, Chicago. Speaker: Aion P. Winnie, M.D. (Coordinator). CME Credit: 15 hrs. AMA Cat. 1. Fee: \$200. Reg. Limit: 35. Sponsor, contact: Cook County Graduate School of Medicine, 707 S. Wood St., Chicago, IL 60612. Attn: Robert J. Baker, M.D., Dean. Telephone: (312) 733-2800.

### Electrocardiography

#### ADVANCED ELECTROCARDIOGRAPHY

For: Internists, Cardiologists. Lecture. March 28 (for 2½ days), Cook County Graduate School of Medicine, Chicago. Speaker: Kenneth Rosen, M.D. (Coordinator). CME Credit: 17 hrs. AMA Cat. 1. Fee: \$125. Reg. Limit: 75. Sponsor, contact: Cook County Graduate School of Medicine, 707 S. Wood St., Chicago, IL 60612. Attn: Robert J. Baker, M.D., Dean. Telephone: (312) 733-2800.

### Family Medicine

#### BASIC INTERNAL MEDICINE

For: General or part-time specialty. Lectures. March 14 (for 5 days), Cook County Graduate School of Medicine, Chicago. Speaker: Sheldon S. Waldstein, M.D. (Coordinator). CME Credit: 40 hrs. AMA Cat. 1; AAP Prescribed. Fee: \$200. Reg. Limit: 100. Sponsor, contact: Cook County Graduate School of Medicine, 707 S. Wood St., Chicago, IL 60612. Attn: Robert J. Baker, M.D., Dean. Telephone: (312) 733-2800.



**DIAGNOSIS & MANAGEMENT OF PROBLEMS IN GYNECOLOGY**

For: Gynecologists; Family Practice physicians. Lecture, March 21 (for 5 days). Cook County Graduate School of Medicine, Chicago, Speaker: Kenneth Rosen, M.D., (Coordinator). CME Credit: 38 hrs. AMA Cat. 1; AAFP Prescribed. Fee: \$200. Reg. Limit: 100. Sponsor, contact: Cook County Graduate School of Medicine, 707 S. Wood St., Chicago, IL 60612. Attn: Robert J. Baker, M.D., Dean. Telephone: (312) 733-2800.

**Family Practice, Medicine****BASIC ELECTROCARDIOGRAPHY**

For: Physicians interested in electrocardiographic interpretation. Lecture, March 21 (for 5 days). Cook County Graduate School of Medicine, Chicago, Speaker: Kenneth Rosen, M.D., (Coordinator). CME Credit: 35 hrs. AMA Cat. 1; AAFP Prescribed. Fee: \$200. Reg. Limit: 45. Sponsor, contact: Cook County Graduate School of Medicine, 707 S. Wood St., Chicago, IL 60612. Attn: Robert J. Baker, M.D., Dean. Telephone: (312) 733-2800.

**Family Therapy****PERSONAL/PROFESSIONAL GROWTH WORKSHOP FOR THERAPISTS; WITH OR WITHOUT PARTNERS**

For: Physicians and Mental Health Professionals. Three-day workshop. March 3, 7:30-4:00 PM; March 4, 8:00 AM-4:00 PM; March 5, 9:00 AM-1:00 PM. Oak Park. Speakers: Charles H. Kramer, M.D., and Jeannette Kramer, F.I.C./C.F.S., MMH & NUMS. Credit: 19 hrs. AMA Cat. 1. Fee: \$125. Individual: \$200 Couple. Reg. limit: 16. Sponsor, contact: The Family Institute of Chicago/Center for Family Studies, 10 E. Huron, Chicago, IL 60611. Attn: Belinda M. Stone. Telephone: (312) 440-1414. Co-sponsors: Northwestern Memorial Hospital & Northwestern University Medical School.

**ANNUAL SPRING CONFERENCE:**

**WORKING WITH BLACK FAMILIES**  
For: Physicians and Mental Health Professionals. Two-day workshop. March 18-19, 9:30 AM-4:30 PM both days. Northwestern University. Speaker: Robert B. Hill, Ph.D., Urban League, Washington, D.C.; Peter Urquhart, Philadelphia Child Guidance Clinic. CME Credit: 14 hrs. AMA Cat. 1. Fee: \$70. Sponsor, contact: The Family Institute of Chicago/Center for Family Studies, 10 E. Huron, Chicago, IL 60611. Attn: Belinda M. Stone. Telephone: (312) 440-1414. Co-sponsors: Northwestern Memorial Hospital & Northwestern University Medical School.

**Hematology****HEMATOLOGY FOR MEDICAL TECHNOLOGISTS**

For: Medical Technologists. 5-day workshop. March 18-22. University of Illinois at Chicago Medical Center, Ann Arbor, MI. CME Credit: CEU credit. Fee: to be determined. Sponsor, contact: Office of Continuing Education, Dept. of PGM/HPE, Towles Center, University of Michigan Medical Center, 48109. Attn: Bette Armbruster. Telephone: (313) 763-0081. Co-sponsor: A.S.M.T.

**Laparoscopy/Obstetrics and Gynecology LAPAROSCOPY, OPEN LAPAROSCOPY, FETOSCOPY, AND HYSTEROSCOPY**

For: Gynecologic laparoscopists. Postgraduate course; three full day sessions with demonstrating in OR. March 30, 31, and April 1, 8:30 AM-5:00 PM. Northwestern Memorial Hospital, Chicago. Speaker: Director: Dr. Melvin R. Cohen. CME Credit: This course has been approved for 30 credits by the American College of Obstetrician and Gynecologists. Fee: \$400. Residents and fellows \$175. Reg. Deadline: March 1. Reg. Limit: 60. Sponsor, contact: Northwestern University Medical School, Section of Graduate and Continuing Education, NUMS, Dept. of Obstetrics and Gynecology, 333 East Superior St., Room 490C, Chicago, IL 60611. Attn: Valerie Vance. Telephone: (312) 698-7508. Co-sponsor: Ann. Association of Gynecologic Laparoscopists.

**Midwest Clinical Conference**

**33rd ANNUAL MIDWEST CLINICAL CONFERENCE**  
For: All physicians. Clinical conference. March 2, 3, 4, and 5, 9:00 AM-5:00 PM. Saturday 9:00 AM-Noon. McCormick Inn, Chicago. CME Credit: 25 hrs. AMA Cat. 1; AAFP Elective. Fee: \$35 non-member. Sponsor, contact: Chicago Medical Society, 310 S. Michigan Ave., Suite 1616, Chicago, IL 60604. Attn: Judy Madel. Telephone: (312) 922-6471. Co-sponsor: Participating Specialty Societies.

**Musculoskeletal Trauma**

**MUSCULOSKELETAL TRAUMA**  
For: Physicians. Clinical hospital program on Trauma. March 15, 8 PM-10 PM. Highland Park Hospital. Speakers: To be announced. CME Credit: 2 hrs. AMA Cat. 1; AAFP Elective. Fee: None. Sponsor, contact: Chicago Committee on Trauma of the American College of Surgeons, 11255 W. 74th St., LaGrange, IL 60525. Attn: Mrs. Lillian Hays. Telephone: (312) 246-3788 or 482-8686.

**REVIEW IN NEUROLOGY, PART I, BASIC**

For: Neurologists, Psychiatrists. Lecture. March 14 (for 5% days). Cook County Graduate School of Medicine, Chicago. Speaker: Catherine Haberland, M.D., (Coordinator). CME Credit: 44 hrs. AMA Cat. 1. Fee: \$225. Reg. Limit: 80. Sponsor, contact: Cook County Graduate School of Medicine, 707 S. Wood St., Chicago, IL 60612. Attn: Robert J. Baker, M.D., Dean. Telephone: (312) 733-2800.

**Pediatrics**

**ADVANCES IN PEDIATRICS**  
For: Pediatricians. 2-day lecture. March 23, University of Michigan Medical Center, Ann Arbor, MI. CME Credit: AMA Cat. 1, AAFP Elective; AOA. Fee: To be determined. Sponsor, contact: Office of Continuing Education, Dept. of PGM/HPE, Towles Center, University of Michigan Medical Center, Ann Arbor, MI 48109. Attn: Bette Armbruster. Telephone: (313) 763-0081. Co-sponsor: American Academy of Pediatrics, Michigan Chapter.

**Psychiatry**

**INSIDE-OUTSIDE: GETTING CLOSER**  
For: Professionals and Students in the Health Field. Lecture. March 2, 7:30-9:30 PM. Forest Hospital Professional Center, Des Plaines. Speaker: Milton H. Glick, M.D., Professor and Chairman, Dept. of Psychiatry, Univ. of British Columbia. CME Credit: 2 hrs. AMA Cat. 1. Fee: \$15 (prof.); \$5 (students). Reg. Limit: 100. Reg. Deadline: advance registration requested. Sponsor, contact: Forest Hospital Foundation, 555 Wilson Lane, Des Plaines, IL 60016. Attn: Leo Jacobs, M.D., Director of Medical Education. Telephone: (312) 827-8811.

**BIOENERGETICS**  
For: Mental health care professionals. Lecture. March 16, 1:00-4:00 PM. Riveridge Hospital, Forest Park, Ga. Speaker: Alexander Lowen, Ph.D., Bioenergetics authority, New York. CME Credit: 3 hrs. AMA Cat. 1. Fee: \$10. Reg. Limit: 200. Reg. Deadline: Reservations: 771-7000 ext. 342. Sponsor, contact: Riveridge Hospital, 8311 W. Roosevelt Road, Forest Park, IL 60130. Attn: John Pontarelli, Community Relations. Telephone: (312) 771-7000 ext. 305.

**QUALIFICATIONS FOR CLINICAL COMPETENCE**

**IN PSYCHIATRY**  
For: Generalists. Distinguished lecture series. March 16, 8:30 PM. Passavant Hospital, Chicago. Speaker: S. Mouchley Small, M.D., Professor and Chairman, Dept. of Psychiatry, State U. of New York at Buffalo. CME Credit: 1 1/2 hrs. AMA Cat. 1. Fee: None. Sponsor, contact: Institute of Psychiatry, Northwestern University Medical School, 320 East Huron, Chicago, IL 60611. Attn: Jeanne Smith. Telephone: (312) 649-8058.

**Surgery**

**GENERAL SURGERY CONFERENCE**  
For: General Surgeons. 2-day workshop. March 14-15. University of Michigan Medical Center, Ann Arbor, MI. CME Credit: AMA Cat. 1; AAFP Elective; AOA. Fee: To be determined. Sponsor, contact: Office of Continuing Education, Dept. of PGM/HPE, Towles Center, University of Michigan Medical Center, Ann Arbor, MI 48109. Attn: Bette Armbruster. Telephone: (313) 763-0081.

**SPECIALTY REVIEW COURSE IN SURGERY, PART II**

For: Surgeons. Lecture. March 14 (for two weeks). Cook County Graduate School of Medicine, Chicago. Speaker: Robert J. Baker, M.D., (Coordinator). CME Credit: 99 hrs. AMA Cat. 1. Fee: \$400. Reg. Limit: 200. Sponsor, contact: Cook County Graduate School of Medicine, 707 S. Wood St., Chicago, IL 60612. Attn: Robert J. Baker, M.D., Dean. Telephone: (312) 733-2800.

**APRIL****EKG**

**ELECTROCARDIOGRAPHIC DIAGNOSIS**  
For: Family physicians, Internists. 3-day workshop. April 25-27. Ann Arbor, MI. CME Credit: AMA Cat. 1; AAFP Elective; AOA. Sponsor, contact: Office of Continuing Education, Dept. of PGM/HPE, Towles Center, University of Michigan Medical Center, Ann Arbor, MI 48109. Attn: Bette Armbruster. Telephone: (313) 763-0081.

**Emergency Medicine**

**ILLINOIS COMBINED SCIENTIFIC ASSEMBLY—"MOVING FORWARD"**  
For: Emergency Care Physicians and Nurses. 2 1/2 day Symposium. April 14-16 (1/2 day for Paramedics). Hyatt Regency O'Hare, Chicago. CME Credit: 20 hrs. AAFP Elective; AOA. Fee: ASEP member \$100, non-member \$110; EDNA member \$80, non-member \$90. Reg. Deadline: May register anytime; late registration fee after March 15. Sponsor, contact: American College of Emergency Physicians, 10316 S. Lawrence, Oak Lawn, IL 60453. Attn: Alan B. Spacone, M.D. Co-sponsor: Emergency Department Nurses Association.

**FAMILY PRACTICE REVIEW**

For: Family physicians. 5-day workshop. Lecture. April 18-22. Ann Arbor, MI. CME Credit: AMA Cat. 1; AOA; AAFP Prescribed. Sponsor, contact: Office of Continuing Education, Dept. of PGM/HPE, Towles Center, Univ. of Mich. Medical Center, Ann Arbor, MI 48109. Attn: Bette Armbruster. Telephone: (313) 763-0081.

**Musculoskeletal Trauma****CLINICAL HOSPITAL PROGRAM ON TRAUMA**

For: All physicians. April 19, 8:00 PM-10:00 PM. Mercy Hospital & Medical Center, Chicago. CME Credit: 2 hrs. AMA Cat. 1; AAFP Elective; Fee: None. Sponsor, contact: Chicago Committee on Trauma of the American College of Surgeons, 11255 W. 74th St., LaGrange, IL 60525. Attn: Mrs. Lillian Hays. Telephone: (312) 246-3788 or 482-8686.

**Ob-Gyn****OBSTETRICS-GYNECOLOGY CONFERENCE**

For: Obstetricians and Gynecologists. 2-day lecture. April 5-6. Ann Arbor, MI. CME Credit: AMA Cat. 1; AAFP Elective; AOA. Sponsor, contact: Office of Continuing Education, Dept. of PGM/HPE, Towles Center, Univ. of Michigan Med. Center, Ann Arbor, MI 48109. Attn: Bette Armbruster. Telephone: (313) 763-0081.

**Psychiatry****"THERE AIN'T NO PILLS, YOU'VE GOT TO DO IT YOURSELF"**

For: Professionals and Students in the Health Field. Lecture. April 13, 7:30 to 9:30 PM. Forest Hospital Professional Center, Des Plaines. Speaker: Robert Goulding, M.D., Director and Co-Founder of the Western Institute for Group and Family Therapy. CME Credit: 2 hrs. AMA Cat. 1. Fee: \$50 prof.; \$5 students. Reg. Limit: 100. Reg. Deadline: Advance registration requested. Sponsor, contact: Forest Hospital Foundation, 555 Wilson Lane, Des Plaines, IL 60016. Attn: Leo Jacobs, M.D. Telephone: (312) 827-8811.

**"RECENT CHANGES IN THE STRUCTURE OF THE FAMILY"**

For: Mental health care professionals. Lecture. April 20, 1:00 PM-4:00 PM. Riveridge Hospital, Forest Park, Ga. Speaker: Bruno Bettelheim, Ph.D., Director Emeritus, Sonia and John Edward Shoenberg School of Univ. of Chicago. CME Credit: 3 hrs. AMA Cat. 1. Fee: \$10. Reg. Limit: 200. Reg. Deadline: Reservations: 771-7000 ext. 342. Sponsor, contact: Riveridge Hospital, 8311 W. Roosevelt Road, Forest Park, IL 60130. Attn: John Pontarelli. Telephone: (312) 771-7000 ext. 305.

**DSM III: RATIONALE, PROBLEMS AND PROSPECTS**

For: Psychosocial and psychiatric lecture series. April 20, 8:00 PM. Passavant Hospital, Chicago. Speaker: Robert L. Spitzer, M.D., Director, Evaluation Section Biometric Research, N.Y. State Dept. of Mental Hygiene, Chicago. CME Credit: 1 1/2 hrs. AMA Cat. 1. Fee: None. Sponsor, contact: Institute of Psychiatry, Northwestern University Medical School, 320 East Huron, Chicago, IL 60611.

**Surgery****SURGICAL ANATOMY REVIEW**

For: Surgical Residents. 4-week workshop. April 4-29. Ann Arbor, MI. CME Credit: AMA Cat. 1; AAFP Elective; AOA. Fee: \$300. Sponsor, contact: Office of Continuing Education, Dept. of PGM/HPE, Towles Center, Univ. of Michigan Medical Center, Ann Arbor, MI 48109. Attn: Bette Armbruster. Telephone: (313) 763-0081.

**CME Planning Aids**

ICCMC continually develops a variety of "how-to" material for CME Planners—DME's, program chairmen of hospitals and medical societies (both specialty and geographic), and others. All items are FREE to Illinois physicians and CME sponsors.

To learn what's currently available, request the "CME Planning Aids Order Form"; write or call . . .

**Illinois Council/CME**  
55 E. Monroe St., Suite 3510  
Chicago, IL 60603  
(312) 236-6110



## EKG

(Continued from page 17)

Answers: 1 E 2 E

The rhythm strip shows atrial tachycardia with irregular atrial cycles. This is best shown in the top and the middle strips where long R-R cycles occur, i.e., after the ninth beat in the top and after the sixth beat in the middle. If one carefully follows the P waves, it can be seen that as the P waves slow the ventricles increase their rate. In other words, the faster atrial rates are accompanied by a greater AV block and longer R-R cycles. The P waves vary from a rate of 150 to 220/minute. It is at these higher rates that greater AV block occurs. This is an example of concealed conduction. At faster atrial rates, more concealment of atrial impulses occurs in the AV node, so fewer reach the ventricles. There is also advanced AV block which is worsened by concealed conduction. All of the drugs listed may potentially worsen the AV block. A demand pacemaker was recommended for the patient. (For a recent review of concealed conduction, see Knoebel and Fisch in the *Cardiovascular Clinics* 5 (3): 21-34, 1973.)

Deluxe nine story medical building, adjacent to Columbus Hospital and Lincoln Park, has suites available for immediate occupancy. Inside parking & full cleaning services. Free moving expenses & two months free rent available

**DOCTORS WANTED**  
Suites: 350 to 6000 sq. ft. from \$8.50 per sq. ft.

### PARK PROFESSIONAL BUILDING

467 W. Deming Pl.  
Chicago, Ill.  
641-7000

McKey & Poague, Inc., Agents

## MANUSCRIPT INFORMATION

Original articles will be considered for publication with the understanding that they are contributed only to the *Illinois Medical Journal*. The *Journal* assumes no responsibility for the opinions and claims expressed in the articles contributed.

Manuscripts should be typed, double spaced, and submitted in duplicate, one original and one carbon. An article should not exceed **12 to 16 manuscript pages**, (including illustrations) and should be briefer if possible. Please enclose personal glossy photos of author or authors. Snapshots are not suitable for reproduction.

References should be numbered in order of appearance in the text and conform to the following style in the order given: name of author, title of article, name of periodical with volume, page, month (day of month if weekly) and year. The *Journal* does not assume responsibility for the accuracy of

references used with articles.

The first page should list the title, the name of the author(s), degrees and any institutional or other credits as well as the author's mailing address. The title should be as short as possible. Pages should be numbered consecutively. Tables are to be typed, numbered and accompanied by a brief descriptive title. Make drawings and charts in black ink. If photographs are submitted, send black and white glossies. Number illustrations consecutively and indicate their place in the text. Number, indicate the top and place the author's name on the back of each illustration.

Address manuscripts to:

T. R. Van Dellen, M.D., Editor  
*Illinois Medical Journal*  
55 E. Monroe St., Suite 3510  
Chicago, Ill. 60603

# Summary of Actions

## 1976 Interim Session

### of the House of Delegates

#### REFERENCE COMMITTEE ON CONSTITUTION AND BYLAWS

1. Amended the Bylaws to incorporate District 1A, established on a temporary basis on April 5, 1975, and composed of Boone, Carroll, DeKalb, JoDavies, Lee, Ogle, Stephenson, Whiteside and Winnebago counties, as the twelfth Trustee District of ISMS. The action also makes permanent expansion of the Board of Trustees membership by two—one from District Three and one from the new District Twelve. The Board quorum was permanently raised from 10 to 11.
2. Agreed to introduce two amendments to the Constitution at the 1977 House of Delegates meeting to be voted upon at the 1978 Annual Meeting. One amendment would remove the designated number of trustees. This would eliminate the slower process required for changes in the Constitution each time the Bylaws are changed to provide for a different number of trustee districts. The second would allow changes in the Constitution to be introduced at either the annual or interim meeting of the House of Delegates. Final action would be taken at the next meeting following the one at which it was first introduced.
3. Approved Bylaws for a Student Business Session and a Resident Physician Section with minor editorial changes. Each group would hold its business session prior to the Annual Meeting to elect its officers and governing council, and ISMS delegate and alternate. They also would nominate representatives to ISMS Councils where such

representatives have heretofore been named. Activities of both new sessions will be financed in accordance with established policies for ISMS activities.

4. Rejected proposals to provide for open membership election of officers and to deny officers the right to vote in the House of Delegates unless they are also elected delegates.

#### REFERENCE COMMITTEE "A"

1. Modified the Society's policy on selection of candidates for AMA positions by providing that consultation with the Board or Executive Committee may be waived in situations wherein positions suddenly become open and speedy nomination is necessary.
2. Directed the Board of Trustees to study the feasibility of compiling a membership roster listing voting addresses. Such a roster would be a useful asset for ISMS legislative activities.
3. Agreed to establish a toll-free telephone number to facilitate grass-roots communication if cost studies show it to be feasible. AMA would be asked to do likewise.
4. Clarified ISMS' policy on opinion polls to limit the need for conducting polls to ascertain membership opinions. While the Board of Trustees may conduct such polls, it is the basic responsibility of the members of the House of Delegates to ascertain the opinion of their constituencies and vote accordingly. Thus, it should be unnecessary for the Board of Trustees to

conduct a membership poll except under very exceptional conditions.

5. Directed the Illinois delegation to the AMA to submit a resolution at the next meeting of the AMA House of Delegates to establish a Section on Administrative Medicine within the AMA. The Section would provide guidelines of ethical conduct for physicians involved in medical administration.
6. Adopted a proposal to create a task force of physicians capable of alerting the public and legislature to the steady drift towards nationalization of health services and referred it to the Board of Trustees for implementation.
7. Directed the Board of Trustees to review future resolutions which call for the Society to support the position of voluntary physician membership organizations not affiliated with ISMS.
8. Reconfirmed ISMS' willingness to cooperate in efforts to solve the fiscal and administrative problems of the Illinois Medicaid program.
9. Rejected were proposals to: (A) Seat alternate delegates with members of the House of Delegates; (B) Remove DuPage county from District 11 and make it an independent District; (C) Send a second mailing of the Ad Hoc Committee on Factoring Companies' report to all members of the House of Delegates; (D) Provide a financial donation in defense of a member who has been sued by a factoring company because such donation would jeopardize the Society's tax exempt status.

#### REFERENCE COMMITTEE "B"

1. Reconfirmed its charge to IFMC to negotiate with government and third parties on behalf of ISMS members with special emphasis on negotiations with IDPA. If these negotiations fail, legal action as feasible was authorized.
2. Supported the concept of confidentiality of the doctor-patient relationship as it relates to office records and directed the Board of Trustees to investigate the legality of IDPA audit procedures.
3. Rejected use of the IDPA Medical Assistance Program Handbook for Physicians

in conducting retrospective audits until it is brought into strict conformity with the Third Edition of the AMA Current Procedural Terminology. As a result of this action, the House rejected 2 similar resolutions calling for ISMS to employ legal action if necessary to prohibit IDPA's use of the Handbook.

4. Directed the Board of Trustees to obtain legal counsel's opinion regarding the most effective method of providing appropriate legal assistance to members and to implement as feasible.
5. Repudiated the unreasonable position of the Department of Public Aid which prohibits physicians from billing the Department in the name of their corporation and directed the Board of Trustees to seek immediate injunctive relief unless administrative negotiation is quickly productive to allow incorporated groups to bill as corporations.
6. Repudiated the dual standard of care resulting from IDPA policy which allows for differentiation in the care rendered to HMO participants and those holding green cards.
7. Objected to arbitrary IDPA-established time limits on payments to physicians and directed legal clarification as to IDPA's obligation to pay past charges which fall outside these limits.
8. Reiterated the long-held principles that: (A) A contractual relationship which exists between a patient and a third party does not involve the physician (unless the physician has agreed to such involvement); (B) The third party is not involved in the contract existing between the patient and his/her physician (unless such involvement has been agreed to by both the patient and the physician).

Strongly objected to insurance company practices of:

- implying to patients that physician's charges above policy allowances are excessive;
- suggesting to physicians that insurance company reimbursement amounts be accepted as payment in full;
- suggesting that physicians perform alternative surgical procedures.

Authorized legal action as necessary and adopted as policy the principles embodied in a "Statement of Understanding" devised by the Board of Trustees in 1972 for doctors to use with their patients. The statement reads as follows:

*"I agree that the determination of professional services to be rendered by my doctor and the fees to compensate him for these services are matters concerning my doctor and me. I understand that I have the primary duty and obligation to pay my doctor for his services, notwithstanding any contract I may have with any third party (be it an insurance company, employer, union, government or the like). Neither my doctor nor I will permit any third party to determine what medical services I need or what fees the doctor should receive in return for these services. Any agreement that either of us may have with any third party shall not affect our doctor-patient relationship and the decisions relating to medical care and fees. Neither my doctor nor I, as his patient, are in any way bound by any contract the other may have with any third party."*

_____	_____
Date	Patient
_____	_____
Witness	Physician

9. Directed the Board of Trustees to formulate a viable definition of peer review and determine appropriate levels of review responsibility.
10. Instructed the Illinois Foundation for Medical Care to restructure its Constitution and Bylaws so that it is completely accountable only to the ISMS House of Delegates and to each component society.
11. Rejected proposals to:
  - A. Allocate resources to assist in the defense of IDPA audits, using the full resources of ISMS, including legal support and injunctive relief if necessary.
  - B. Seek injunctive relief to: (1) Halt unreasonable, retrospective and unfair IDPA audits of physician records by lay personnel; and (2) Prohibit IDPA from seizing medical records.
  - C. Direct ISMS or the Illinois Foundation for Medical Care to work for removal of the current IDPA regulation which permits only one initial examination for a Medicaid patient, even if a physi-

cian in a group practice who is new to the case believes a second examination is warranted.

- D. Criticize the IDPA Medical Advisory Committee for its handling of issues related to the Medical Assistance Program Handbook for Physicians.

## REFERENCE COMMITTEE "C"

1. Clarified existing policy on drugs and prescriptions to specify that public health departments should not conduct drug dispensing and distribution programs without direct physician supervision of the patients receiving medication. The House also revised its policy on immunization to state that Illinois residents should be provided "access to all medically indicated immunizations" rather than "all types of immunization" as formerly stated.
2. Opposed any legislation which mandates the inclusion of insurance benefits for medical care of psychiatric illness in insurance policies on an optional basis.
3. Agreed to take whatever legislative action necessary to ensure that involuntary psychiatric hospital certification will in all cases remain the responsibility of a physician licensed to practice in all branches of medicine without exception.
4. Supported the concept of payment for second opinion prior to elective surgery as long as the free choice of physicians is maintained. The House also directed that Blue Cross/Blue Shield be notified that ISMS endorsement of this practice is predicated on usual and customary referral patterns.
5. Rejected a proposal calling upon Blue Cross/Blue Shield to allow physicians—as well as patients—to request a second opinion prior to elective surgery.

## REFERENCE COMMITTEE "D"

1. Commended Dr. Leonard Berlin for his courage and commitment to justice in winning a landmark decision involving counter-litigation.
2. Referred two resolutions relating to "Death with Dignity" or "Right to Die" legisla-



tion to the Board of Trustees for further study.

3. Requested the Task Force on Professional Liability to continue its dialogue with the Illinois Supreme Court.
4. Opposed all federally mandated national health insurance programs proposed thus far and instructed the Illinois delegation to the AMA to support this position in the AMA House of Delegates.
5. Amended the ISMS policy on hospital records and their availability to comply with newly-enacted legislation. The amended policy reads as follows:

*"Patient care hospital records contain privileged information of confidential nature. Such records are the property of the hospital; information contained therein is held in trust, through a fiduciary relationship, by the hospital.*

*"Patients, and upon appropriate, written authorization, their attorney or succeeding physician, have the right of access to these records, with the ability of review and the right to copy or receive copies. This access is not afforded to patients in cases of psychiatric illness. "Upon receipt of proper, written authorization from the patient, a copy, abstract or summary shall be provided as required to insurance companies, governmental agencies, or other hospitals. "Patient records utilized by official committees of organized medical staffs to accomplish scientific studies of morbidity or mortality, utilization review, peer review or other patient care improvement activity remain confidential and shall not be disclosed to any person outside the purview of such committees.*

*"In certain instances involving litigation, a physician may have to release medical records in the absence of a signed patient authorization. In those instances, a physician should make sure that he is required to release the medical records and that the authority so requiring the release is proper and appropriate."*

6. Supported programs designed to identify physicians engaged in Medicaid fraud and abuse. The House also directed that members be advised of: (A) Federal and state laws governing Medicaid reimbursement claims for laboratory services; (B) Illegalities relating to rebate arrangements and mark-up charges and the legal consequences of these practices; and (C) that reasonable fees for the collection and processing of specimens and professional interpretation of outside laboratory results are per-

missible. The House directed that ISMS seek amendment to the present discriminatory laboratory law to ensure the equitability of its administration.

7. Requested the Board of Trustees to study the feasibility of legislation which would limit use of the word "physician" to persons licensed to practice medicine in all its branches.
8. Referred to the Board of Trustees the "Captain of the Ship" concept of responsibility in operating rooms, as related to non-physician anesthetists and anesthesiologists.
9. Instructed the ISMS delegation to the AMA to support the Oregon State Medical Association resolution opposing legal attacks on the use of the relative value studies.
10. Rejected were proposals to:
  - A. Seek legislation extending the "benefits" of utilization review to other tax-supported professions.
  - B. Urge IRS to simplify Form 4452; provide authorization for physicians to release the requested information; and compensate physicians for completing the form.
  - C. Modify the Illinois anti-substitution law.

## IN GENERAL

In other actions the House of Delegates urged HEW to alert local public health authorities and tuberculosis control agencies when the immigrant population entering their area includes persons with a previous active history of tuberculosis.

The following reports were reviewed and filed for information: Executive Administrator, Chairman of the Board of Trustees, Committee on Redistricting, Committee on Governmental Health Program Reimbursement, Illinois Foundation for Medical Care, Task Force on Professional Liability, Illinois State Medical Inter-Insurance Exchange, Illinois State Medical Insurance Services, Inc.

# Actions on Resolutions

## November, 1976 Interim Session

### House of Delegates

<i>Number</i>	<i>Introduced By:</i>	<i>Subject</i>	<i>Action</i>
76N-1	George Lagorio	State Medical Advisory Committee Problems	Not accepted for consideration
76N-2	Allan L. Goslin	Revised Policy on Drugs, Prescriptions	Adopted as amended
76N-3	Allan L. Goslin	Revised Policy on Immunization Programs	Adopted as editorially changed
76N-4	George Lagorio	Public Aid Publication Resolutions	Not accepted for consideration
76N-5	George Lagorio	The Illinois Physicians Union Advertising Resolution	Not accepted for consideration
76N-6	George Lagorio	Illinois Department of Public Aid Negotiating Resolution	Not accepted for consideration
76N-7	George Lagorio	The Late Resolutions Committee Investigation	Not accepted for consideration
76N-8	George Lagorio	Chicago Medical Society Advertising	Not accepted for consideration
76N-9	George Lagorio	Censure	Not accepted for consideration
76N-10	George Lagorio	H.B. 28-32 Licensing Medical Factoring Companies	Not accepted for consideration
76N-11	Finley W. Brown, Jr.	Reconfirmation of Original Resolution	Adopted as amended
76N-12	Finley W. Brown, Jr.	Auditing of Physicians by Governmental Agencies	Rejected
76N-13	Finley W. Brown, Jr.	Bureaucratic Harassment by Non-Peer, Unfair Review	Rejected
76N-14	Finley W. Brown, Jr.	Cooperation on Costly Litigation	Substitute adopted as amended
76N-15	Finley W. Brown, Jr.	Incorporated Physicians in Medical Groups	Adopted as amended
76N-16	Finley W. Brown, Jr.	Unacceptable Rules and Regulations	Rejected
76N-17	Finley W. Brown, Jr.	Illegal Release of Medical Records	Rejected
76N-18	Finley W. Brown, Jr.	Two Standards of Medical Care	Adopted as amended

<i>Number</i>	<i>Introduced By:</i>	<i>Subject</i>	<i>Action</i>
76N-19	Finley W. Brown, Jr.	Economic Review of Medical Records	Rejected
76N-20	Finley W. Brown, Jr.	Individual Physician Responsibility in Group Practice	Rejected
76N-21	George Lagorio	Unified Foundation Membership Unfair	Withdrawn
76N-22	George Lagorio	The Illinois Foundation for Medical Care Negotiation Update	Not accepted for consideration
76N-23	John J. Ring	Revised Policy on ISMS Candidates for AMA Positions	Adopted
76N-24	Herschel Browns	Leonard Berlin, M.D.	Adopted
76N-25	Gonzalo Ruiz	Medical Advisory Committee to Public Aid	Rejected
76N-26	Jos. R. O'Donnell	Redistricting	Rejected
76N-27	Jos. R. O'Donnell	Insurance Benefits for Psychiatric Illness	Adopted
76N-28	Jos. R. O'Donnell	Involuntary Psychiatric Hospital Certification	Adopted as amended
76N-29	Fred Z. White	Providing for District 1A on a Permanent Basis by April 5, 1977	Adopted as amended
76N-30	H. Frank Holman	"Death with Dignity" or "Right to Die Legislation"	Referred to Board of Trustees
76N-31	George Lagorio	Dr. Hutchinson Defense Fund	Rejected
76N-32	George Lagorio	Illinois Physicians Suit against HEW & IDPA	Not accepted for consideration
76N-33	George Lagorio	IDPA Injunction	Not accepted for consideration
76N-34	George Lagorio	Blue Cross/Blue Shield Second Opinion	Rejected
76N-35	George Lagorio	Ad Hoc Committee on Factoring Companies	Rejected
76N-36	Wayne Leimbach	Petition to the Chief Justice of the Ill. Supreme Court for Correction of Abuses by the Legal Community of Ill. Leading to Accentuation of the Medical Malpractice Problem	Substitute adopted
76N-37	Wayne Leimbach	Utilization Review and Equal Treatment before the Law	Rejected
76N-38	George T. Wilkins	Member Mailing Addresses	Substitute adopted
76N-39	George T. Wilkins	Establishing Toll-Free Telephone Number	Substitute adopted
76N-40	George T. Wilkins	Opposition to National Health Insurance Plans	Adopted as editorially changed

<i>Number</i>	<i>Introduced By:</i>	<i>Subject</i>	<i>Action</i>
76N-41	Allan L. Goslin	Opinion Polls	Adopted as amended
76N-42	George Lagorio	IDPA Reimbursement Time Limit Resolution	Adopted
76N-43	George Lagorio	Welfare Recipient Consent Resolution	Adopted as amended
76N-44	George Lagorio	IDPA Medical Assistance Program Handbook for Physicians	Adopted as amended
76N-45	George Lagorio	One Man One Vote Resolution	Rejected
76N-46	Herschel Browns	Vote of Officers & Members of Board of Trustees in House of Delegates	Rejected
76N-47	George Gertz	Physicians Reimbursement for Completion of IRS Form 4452	Rejected
76N-48	Jos. R. O'Donnell	Third Party Intervention into the Practice of Medicine	Adopted as amended
76N-49	Robert T. Fox	Prudential Insurance Co. Practice of Requesting that Physician be Satisfied with Reimbursement Amounts as Total Payment for Medical Services Rendered	Adopted
76N-50	Allan L. Goslin	Hospital Records & their Availabil- ity; Modification of Policy Manual	Adopted
76N-51	Robert T. Fox	Legal Consequences of Rebate Arrangements with Clinical Laboratories	Adopted as amended
76N-52	William Dunn, Student Delegate	Approval of Constitution & Bylaws for Student Business Session of the ISMS	Adopted as editorially corrected and amended
76N-53	Paul Stromborg	Resident Physicians Section Constitution & Bylaws	Adopted as editorially corrected and amended
76N-54	Morris T. Friedell	AMA Section on Medical Administration	Adopted as amended
76N-55	Robert J. Becker	Definition of Peer Review	Substitute adopted
76N-56	Robert J. Becker	Notification of Third-Party Carriers	Rejected
76N-57	Harry W. Darland	Use of Term, "Physician" by Persons not Licensed to Practice Medicine in All Its Branches	Referred to Board of Trustees
76N-58	Richard A. Arnell	Seating of Alternate Delegates	Rejected
76N-59	James W. Sutherland	Public Relations, The Lack Of	Referred to Board of Trustees for implementation
76N-60	James W. Sutherland	"Captain of the Ship" Responsibility in Operating Room	Referred to the Board of Trustees



<i>Number</i>	<i>Introduced By:</i>	<i>Subject</i>	<i>Action</i>
76N-61	Robert T. Fox	Modifying Drug Anti-Substitution Law	Rejected
76N-62	Elliott Partridge	"Death with Dignity" or "Right to Die" Legislation	Referred to Board of Trustees
76N-63	P. John Seward	Anesthesiology Suit	Adopted as amended
76N-64	George Wilkins	IFMC Membership & Affiliation Requirements	Substitute adopted
76N-65	Robert T. Fox	Consultation Lists Developed by Third Party Payors	Substitute adopted
76N-66	David Fox	Resolutions Referring to Organizations not Affiliated with ISMS	Adopted as amended
76N-67	Robert Johnson Edward DuVivier Robert Becker Robert Prentice	Administrative Reform of Medicaid	Adopted as amended
76N-68	Illinois Delegation to AMA	Tuberculosis Control	Approved

# MARK YOUR CALENDAR

## ANNUAL MEETING OF THE ILLINOIS STATE MEDICAL SOCIETY

**April 24 through 27, 1977**

This year's annual meeting will be held in Chicago's newest hotel in the SKY, the HOLIDAY INN-MART PLAZA, Orleans Street at the Merchandise Mart. Shopping, banking and many other facilities are accessible in the hotel. Free parking is provided for guests. The Holiday Inn-Mart Plaza has restaurants, show lounges, and an indoor swimming pool. Plan to bring the family to the ISMS Annual Meeting, and enjoy the many "extras" of the most complete RESORT hotel in Chicago.

## Doctor's News

**CLINICAL DEPRESSION** is the subject of two nationally televised specials designed to aid the primary care physician in diagnosis and effective treatment of the mentally depressed patient. Channel 9 in Chicago will air Part I of the program on January 20 from 7:00 to 7:30 a.m. The second televised portion of the course will be carried in the early part of March, 1977. Supplementary literature will complete the five part series, which is presented and sponsored by the University of Pennsylvania Department of Psychiatry under a grant from Pfizer Laboratories Division, Pfizer, Inc. The course will consider the history of mental depression over 25 centuries of Western Civilization as well as recent progress and theory in treatment. The course has been approved for up to 9 Category I credits toward the AMA Physician's Recognition Award.

**DANGEROUS DRUGS UPDATE**—The Department of Registration and Education Medical Disciplinary Board is conducting an investigation of 40-60 Illinois physicians who write prescriptions for controlled substances. A cross-indexed computer printout listing physicians, patients, pharmacies and individuals is being developed monthly from information on official triplicate prescription forms for designated products. Although 400-600 physicians are being monitored by means of the printout, the 10% under actual investigation have been so notified. Those who have not received such notification should not infer that they are subjects of inquiry at the present.

**CHILD ABUSE MANUAL AVAILABLE**—The Child Advocate Association has published a manual entitled "Hospital Guidelines for the Management of Suspected Child Abuse and Neglect Cases" which is available to Illinois hospitals. The guide, which is cosponsored by the Chicago Hospital Council, deals with medical, legal and social service problems in child abuse and neglect cases. One free copy is available upon request to interested physicians, and additional copies may be obtained for \$3.00. Interested members are urged to write Peter Coolsen, acting director, The Child Advocate Association, 19 South LaSalle Street, Suite 401, Chicago, 60603.

**ANNUAL IPS DINNER**—Alex J. Spadoni, M.D., president of the Illinois Psychiatric Society, has announced that the Society will hold its annual dinner on March 9 at the Drake Hotel in Chicago. The featured speaker will be Richard Green, M.D., Professor of Psychiatry and Psychology, State University of New York, Stony Brook. Dr. Green will discuss "Children of the Sexually Atypical," an analysis of the offspring of homosexuals and transsexuals. Reservations are required. For further information, please contact Wendy J. Smith, Illinois Psychiatric Society, 55 East Monroe, Suite 3510, Chicago (312/782-1654).

**ALCOHOL TREATMENT LICENSING ACT**—A complete copy of the regulations governing alcoholism and intoxication treatment programs under Illinois law may be obtained by writing the Illinois Department of Public Health, 535 W. Jefferson Street, Springfield, 62761.

**PHYSICIANS IN THE NEWS**—Dr. Mitchell V. Kaminski, Jr., was recently appointed director of medical education and research at St. Mary of Nazareth Hospital Center in Chicago. The former assistant chief of the Physician Sciences Division for the U.S. Army Medical Research Institute of Infectious Diseases at Fort Detrick, Maryland, Dr. Kaminski is widely published and also known for his work in producing audio-visual aids for continuing medical education. Dr. Anthony Sapienza was named vice president for medical affairs at the hospital. Dr. Sapienza, who has served as director of medical education at St. Mary's since 1968, is a clinical associate professor of medicine at the University of Illinois.

George Kroll, M.D., Chicago, has been appointed chairman of the Department of Internal Medicine and director of the Medical Residency Training Program at Edgewater Hospital, as well as professor of medicine at Chicago Medical School.

Dr. Louis Limarzi, a staff hematologist at Augustana Hospital and Health Care Center, Chicago, has been named "Alumnus of the Year" by the University of Illinois Medical Alumni Association. Dr. Limarzi joined the Augustana staff in 1960 and has served as professor of medicine with the UI since 1962.

Newly elected members of the medical staff at Christ Hospital in Oak Lawn include Alfred P. Ricker, M.D., president, Henry Evenhouse, M.D., secretary, and delegates-at-large William McKenna, M.D. and Julius Brant, M.D. A number of Illinois physicians have been admitted as Fellows of the American College of Chest Physicians. Dr. Theodore S. Eisenman, Dr. Robert M. Gasior, Dr. John J. Lamberti, Dr. Sidney Levitsky, Dr. Melvin Lopata, Dr. Javad Malek, Dr. Arthur S. Palmer, Dr. Leon Resnekov, Dr. Donald H. Singer, Dr. Robert I. Slott and Dr. Paul A. Thomas, Jr., comprise the listing of Chicago physicians receiving the honor. Joseph C. Cleveland, M.D., from Urbana and Ira M. Levenson, M.D., Champaign, also have been admitted as Fellows. Dr. I. Joe Ihm, Elgin, Dr. Manohar L. Jasuja, Oak Brook, Dr. Charles E. Montgomery, Peoria, Dr. Glennon H. Paul, Springfield and Dr. Rong S. Tu of Lombard complete the total of 18 Illinois physicians most recently admitted to the College.

**HYPERTENSION LECTURE SCHEDULED**—The twenty-first annual James B. Herrick Memorial Lecture will be held Thursday evening, February 3, 1977, at the Palmer House in Chicago. Featured speaker Harriet P. Dustan, president of the American Heart Association, will discuss "Patho-physiology and Pathogenesis of Hypertension." For dinner reservations, contact the Chicago Heart Association, 20 N. Wacker Drive, Chicago, Illinois, 60606, (312/FI-6-4675).

**THE CHICAGO MEDICAL SOCIETY** has added three new field representatives to its Membership Services staff. Mark Tauber, Steve Ellwing and Bob Hughes will be working to serve area physicians.

**DES SONS**—A team of researchers from the University of Southern California have found the male offspring of women taking DES during pregnancy experience a significantly high rate of urogenital disease. A report published in the October issue of *Pediatrics* reveals the results of a survey of male offspring of DES mothers. The researchers find that 1.8% of the unexposed male population have experienced urogenital problems, while 12.9% of those exposed to DES *in utero* reported diseases of the urinary tract.

(Continued on page 70)

## The Constitution Our Greatest Ally



In DeKalb, I was asked to name the AMA's greatest strength in protecting the nation from ill-advised attempts to put the practice of medicine under bureaucratic control. "The courts," I answered; then added after further thought, "the Constitution of the United States."

Even so, the AMA took to the federal courts for the first time in history in 1975, challenging laws and HEW regulations. In another major and successful use of the Constitution, court action was threatened against certain aspects of the Medical Manpower Act.

The first, fourth, fifth, ninth and fourteenth amendments, which express some basic tenets of our democracy, were cited by the AMA in actual or threatened litigation. In protecting the rights of individuals from the state, the Constitution also provides a basis for private medical care in this country, a superior system more decent and humane than any government-dominated health system in the world.

This system is not perfect, but it is getting better. It must involve all sectors of society both private and public, but any changes must take place within the framework of the Constitution, in order that the public, including the medical profession, might continue to enjoy the protection of that Constitution.

If the practice of medicine is to be excluded from that protection, then we would see a new type of domino theory, with erosion of the rights of all of our people.

*Joseph H. Skom, M.D.*

Joseph H. Skom, M.D.





**RECENT CHANGES**

**federal register**

**Providing  
Drug Information  
to Physicians**

**Informational  
Bulletin #433-76**

**National  
Health  
Insurance**

**special report**  
**Malpractice  
Insurance:**

**drug  
bulletin**

**Health care doesn't  
need more red tape**

**Drug firms challenge  
'MAC' rules**

**Drug  
Substitution**

**The Continuing Documentation  
of Health Progress  
RESEARCH**

**Mailgram 2**

# THERE ARE A LOT OF PEOPLE GETTING BETWEEN YOU AND YOUR PATIENT.

Medicine today is in the spotlight, subjected to all kinds of scrutiny. Your control over patient therapy is being monitored, judged and occasionally abrogated, sometimes by unknown third parties.

The worry is that in the wake of this focus, the relationship between you and your patient will be weakened, without offsetting benefits. Consider three examples:

**Drug substitution** In most states, pharmacy laws, regulations or professional custom stipulate that your non-generic prescriptions be filled with the precise products you prescribe. But in the last five years, a dozen or more State laws have been changed, permitting the pharmacist in most cases to select a product of the same generic drug to fill any prescription.

Ironically, this dilution of physician control has taken place against a background of growing evidence that purportedly equivalent drug products may be inequivalent, since neither present drug standards nor their enforcement are optimal. In fact, the FDA itself says it has not enforced the same standards for hundreds of "follow-on" products that it had applied to the original NDA approvals. Thus physician control over patient therapy is being eroded with a risk that patients may be exposed to drugs of uncertain quality.

The major advertised claim for substitution is reduced prescription prices for consumers. Yet no documentation of any significant savings has been produced.

**MAC** Maximum Allowable Cost, MAC for short, is a Federal regulation designed to cut the Government's drug bill by setting price ceilings for drugs dispensed to Medicare and Medicaid patients. Unless the prescriber certifies on the prescription that a particular product is medically necessary, the Government intends to pay only for the cost of the lowest-priced, purportedly-equivalent,

generally-available product. The effect of the program may be that elderly and indigent patients will be restricted to products which someone in Washington believes are priced right. Practicing doctors will have little to say about administration of the program, since Government will have absolute authority to make its choices stick.

**The drug lag** The future of drug and device research depends upon a scientific and regulatory environment that encourages therapeutic innovations. The American pharmaceutical industry annually is spending more than \$1 billion of its own funds and evaluating more than 1,200 investigational compounds in clinical research. Disease targets include cancer, atherosclerosis, viruses and central nervous system disorders, among others. But there is a major barrier to the flow of new drugs to your patients: The cost of the research is more than ten times what it was, per product, in 1962; and whereas governmental clearance of new drug applications took six months then, it commonly consumes two years now.

The FDA needs adequate time, of course, to consider data. But it is equally clear that the present approval process contributes to needless delay of needed therapy. That's why the increased efficiency of the drug approval process is vital to all our futures.

If these issues concern you, we suggest that you make your voice heard—among your colleagues and your representatives in State legislatures and in Washington.

It could make a difference in your practice tomorrow.



Pharmaceutical Manufacturers Association  
1155 Fifteenth Street, N.W., Washington, D.C. 20005

# Cut the Risk of a Malpractice Suit

## Make an ISMS Action Call

**312/782-1722**

To help physicians become more aware of the legal aspects of patient care, the ISMS Task Force on Professional Liability created ISMS ACTION CALL. This telephone information system gives you access to a constantly expanding library of taped messages which can help you minimize your chances of being sued. The library also contains tapes which outline what to do if you are sued and how to counter frivolous litigation.

ISMS ACTION CALL is not intended to establish or imply a standard of care or to supplant advice of personal legal counsel. However, each tape has been carefully researched and presents authoritative information. The messages are between two and five minutes in length.

You can consult the ISMS ACTION CALL tape library between 9 a.m. and 4:30 p.m., Monday through Friday. Dial (312) 782-1722 and ask for the tape by number.

### **No. PREVENTION/DEFENSE**

1. Communication Can Prevent Litigation
2. Medical Records . . . A Key to Your Defense
3. Good Prescribing Habits Can Keep You Out of Court
4. Obtaining Patient Consent That Will Stand Up in Court
5. Parental Consent in Treatment of Minors . . . When It's Needed

### **SUITS/INSURANCE**

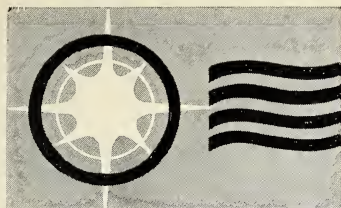
6. What Happens When You're Sued
7. Dangers of Dropping Malpractice Coverage

### **COUNTER MOVES**

8. Filing a Countersuit
9. Recovering Defense Costs Through Section 41
10. Initiating Disciplinary Action Against Attorneys

The availability of additional tapes will be announced in the *ISMS Action Report* newsletter and the *Illinois Medical Journal*. ISMS ACTION CALL is another service made possible by funds from the special dues assessment voted in November, 1975, by the House of Delegates.





## membership forum

### An Open Letter

Members of ISMS Medical-Legal and Governmental Affairs Councils:

There exists today a great deal of controversy surrounding the "social responsibility" of state-supported medical schools in their selection among applicants for medical training. It is indeed tragic that in decades past many were excluded from the wonderful opportunity for medical training solely on the basis of their race, religion, or sex. In this way, a great deal of talent and creativity was squandered. As well it should have, America has hung its head in shame for this travesty on individual freedom. In recent years, many Americans, in the name of "social responsibility," have sought to rectify this past crime by REINTRODUCING THE PRINCIPLE THAT MADE IT POSSIBLE; namely, establishing race and sex as criterion for admission to state-supported medical schools.

Many have spoken with great eloquence of the social obligations of these centers of medical education. But, in fact, a "social obligation" is nothing more than a euphemism for the personal prejudices of the powers that be. Each medical school is justly assigned the responsibility of training physicians; not social engineering. Each year thousands upon thousands of young Americans seek medical training with the eagerness of a life's ambition, only to be denied this opportunity. Let it be said that they were so denied because they were not among the most talented applicants; not because their skin color or sex was not "socially appropriate." To insist that "minority" applicants, whose ancestors fell victim to discrimination, should now receive preferential treatment in seeking admission to medical schools is to seek to re-establish a principle that discriminates against non-minority members (no less a blemish on individual freedom and human dignity) and that potentially can and very likely will be used in the future by bigots striving to oppress a minority.

It was once said that the road to Hell is often paved with good intentions. And this is precisely where this type of reckless policy will take America. It remains for the policy-determining branch of the Illinois State Medical Society to accept its responsibility by addressing this issue, and proposing legislation that will insure that only talent will be accepted as a just factor of discrimination among applicants for admission to medical schools.

STEVE FIELD  
Student Member,  
Illinois State Medical Society





## report

Illinois Society  
American Association of Medical Assistants

# "ASSERTIVENESS — COMMUNICATION — REHABILITATION"

*Seventh Annual "Medical Assistants Workshop" at the  
Midwest Clinical Conference — Chicago Medical Society*

Wednesday, March 2, 1977  
McCormick Inn, Chicago

- 8:00 a.m.** Registration . . . Coffee/Rolls  
**8:45 a.m.** Welcome: Mrs. Ruby Jackson, CMA, President,  
A.A.M.A. Illinois Society
- Morning Session:**  
**9:00 a.m.** "ASSERTIVENESS TRAINING"  
Jane E. Meyers, M.A., Certified Social Worker,  
Director of Contemporary Adlerian Learning Center, Evanston, IL.  
**12:00 noon** Visit Scientific and Technical Exhibits  
**1:00 p.m.** Luncheon.
- Afternoon Session:**  
**2:00 p.m.** "DISABILITY PROCESS: WHO-WHAT-WHEN"  
Bernard Levine, Ph.D., Director of Psychological Services,  
Rehabilitation Institute, Chicago.  
**3:00 p.m.** Adjournment

A.A.M.A. approval for CEU (continuing education unit) credits pending.  
Mrs. Luella Mitchell, Chairman & Program Co-ordinator  
Mrs. Edith Whelan, Chairman, Luncheon Arrangements  
Registration fee: \$10.00 (luncheon included)  
Early registration requested—before February 23, 1977

---

please detach and mail to: Mrs. L. Mitchell, 7920 S. Eberhart, Chicago, 60619

---

\$10.00—payable to: AAMA-Illinois Society

Name \_\_\_\_\_ AAMA chapter member \_\_\_\_\_ Non member \_\_\_\_\_  
Address \_\_\_\_\_

# "FOUR MINUTES TO LIVE BY"

## CPR All Day Workshop

Sunday, February 13, 1977

Robert Morris College

430 N. Michigan — Chicago

- Arranged by: American Association of Medical Assistants  
Illinois Society—CHICAGO CHAPTER
- Co-ordinated by: Mr. Frank Gifford, CPR program co-ordinator
- In cooperation with: Chicago Heart Association
- 9:00 a.m.** Registration . . . coffee/rolls
- 9:30 a.m.** Welcome . . . Mrs. Anna Albert, President, Chicago Chapter, AAMA
- Morning session:** What is CPR? Why teach CPR?  
Emergency care and the role of the rescuer  
Overview of Chicago Heart Association CPR program
- 10:00 a.m.** "The Pulse of Life" (film presentation)  
What are the early warning signs, risk factors.  
Other medical emergencies requiring CPR.  
The effectiveness-complications-medico-legal aspects of CPR.
- 11:30 a.m.** Luncheon
- Afternoon session:**
- 12:30 p.m.** *Demonstrations:* Teaching basic techniques  
Ventilation-airway obstruction maneuvers-special problems-pre-cordial  
thump-external cardiac arrest-witnessed & unwitnessed arrest  
Infant resuscitation: single or two rescuers
- 1:30 p.m.** Manikin practice
- 3:00 p.m.** Performance testing
- 4:30 p.m.** Adjournment

Mrs. Bonnie Harper, Program Chairman—Mrs. Ronnie Cassano, Vice Chairman

Early registration requested (participants limited to the first 75)  
before February 1, 1977.

-----  
Please detach-mail to Ms. Rita Martin, 6639 S. Bishop St., Chicago 60636  
-----

Registration fee: \$10.00 (luncheon included) payable to A.A.M.A., Chicago Chapter.

Name \_\_\_\_\_ AAMA chapter member \_\_\_\_\_ Non-member \_\_\_\_\_

Address \_\_\_\_\_

## Guest Editorial

# *Visiting Professor Program*

*By Mather Pfeifferberger, M.D.*

Would you like an opportunity to pick the professor's brain in your own hospital setting? That is exactly what you can do under the Visiting Professor Program recently inaugurated by your Illinois Council on Continuing Medical Education (ICCME).

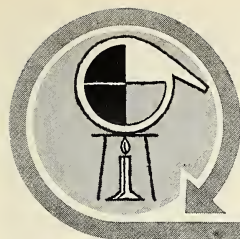
The proposal was officially adopted by the ICCME about a year ago and four very successful "pilot runs" have been completed at community hospitals. The program was developed as a specific activity to link medical schools with community hospitals.

As the program develops it should also prove to be a valuable aid in bridging "the understanding gap" which regrettably still exists to an unfortunate degree between the private practitioner and teaching-research sectors of the medical profession. Both groups are very necessary to the maintenance and delivery of good health care to our populace. Mutual understanding of and respect for each group's roles and problems could do much to calm the emotional outbursts and unwarranted criticisms leveled at the entire medical profession by critics who in many instances have been improperly informed by some of our own professional colleagues.

The visiting professors chosen for community hospital visits represent a consensus formed by the medical staff of the community hospital, a representative of the participating medical school, and the Executive Director of the ICCME. In this manner, it is hoped that the learning needs and interests of the medical staff will be met successfully, and in turn the visiting professor will keep in touch with the problems encountered in a dynamic clinical environment.

The Visiting Professor Program is in its infancy and is now available only to those community hospitals which have a continuing medical education program accredited by the Illinois State Medical Society and the AMA Council on Medical Education.

Shouldn't you stimulate your medical staff colleagues now to seek accreditation of your hospital's continuing medical education program? It makes good sense from a number of aspects. The availability of the Visiting Professor Program is but one possible benefit. Contact the ICCME office for more information — 55 East Monroe Street, Suite 3510, Chicago, Illinois 60603 (telephone: 312-236-6110).



# new pharmaceutical specialties

By PAUL DEHAEN

For detailed information regarding indications, dosage, contraindications and adverse reactions, refer to the manufacturer's package insert or brochure.

**New Single Drugs**—Drugs not previously known, including new salts.

**Duplicate Single Drugs**—Drugs marketed by more than one manufacturer.

**Combination Products**—Drugs consisting of two or more active ingredients.

**New Dosage Forms**—Of a previously introduced product.

The following new drugs have been marketed:

## NEW SINGLE DRUGS

**AMIKIN** Antibiotic Rx  
Manufacturer: Bristol Laboratories  
Nonproprietary Name: Amikacin sulfate  
Indications: Short-term treatment of serious infections due to susceptible strains of Gram-negative bacteria

Warning: Potential ototoxicity and nephrotoxicity

Dosage: i.m. or i.v. administration, follow instructions in package insert

Supplied: Solution: 2 ml/100 mg  
2 ml/500 mg  
4 ml/1 g

**KINEVAC** Cholecystokinetic Rx  
Manufacturer: E. R. Squibb & Sons, Inc.  
Nonproprietary Name: Sincalide (Octapeptide of cholecystokinin)

Indications: To produce contraction of the gallbladder for diagnostic purposes

Dosage: 0.02 mcg per kg, given i.v.  
Supplied: Vials, 5 mcg

## DUPLICATE SINGLE DRUGS

**DEXAMPLEX** Amphetamine Rx  
Manufacturer: Lemmon Pharmaceutical Company  
Nonproprietary Name: Dextroamphetamine sulfate  
Indications: Narcolepsy and minimal brain dysfunction

Contraindications: Those usual for amphetamines  
Dosage: Narcolepsy—5 to 60 mg per day  
Minimal brain dysfunction—

Children 3 to 5 yrs, 2.5 mg daily

Children 6 yrs. or older, 5 mg once or twice daily

Dosage may be increased to optimal level

Supplied:

**DIAZACHEL**  
Manufacturer: Ataraxic Rx  
Nonproprietary Name: Rochelle Laboratories, Inc.  
Indication: Chlordiazepoxide  
Dosage: Anxiety and tension  
Adjust to requirement of each patient

Supplied:

**MOBISYL Creme**  
Manufacturer: Topical analgesic otc  
Nonproprietary Name: B. F. Ascher & Company, Inc.  
Indications: Triethanolamine salicylate  
Pain in arthritis, muscular aches, neuralgias and sprains

Administration: Rub into areas of pain three or four times daily and before retiring

Supplied:

Tablets, 5 and 10 mg  
Capsules, 15 mg

Tablets, 5, 10, 25 mg

Tubes, creme 20%

## COMBINATION PRODUCTS

**EMPRACET** Analgesic Rx  
Manufacturer: Burroughs Wellcome & Co. (USA) Inc.

Composition: Codeine phosphate 30 mg  
Acetaminophen 300 mg  
Indication: Moderate to severe pain  
Dosage: 1 to 2 tablets every four hrs.  
Supplied: Tablets

**PEROCET-5** Narcotic-Antipyretic Rx  
Manufacturer: Endo Laboratories, Inc.  
Composition: Each Tablet contains:

Oxycodone HCl 5 mg  
Acetaminophen 325 mg  
Relief of moderate to moderately severe pain

Warnings: Oxycodone can produce drug dependence. Do not administer to children  
One tablet every six hours as needed  
Supplied: Tablets

**PROMEX Expect.** Cough Preparation Rx  
Manufacturer: Lemmon Pharmaceutical Co.  
Composition: Promethazine HCl 5 mg  
Ipecac fl. ext. 0.011 ml  
Potassium guaiacolsulfonate 44 mg  
Alcohol 7%/5 ml

Indications: Symptomatic relief of coughs  
Dosage: 1 to 2 tablespoon every 4 to 6 hrs.  
Supplied: Bottles, 4 oz.



## Doctor's News

(Continued from page 60)

**IN A RELATED NOTE**—The National Cancer Institute Division of Cancer Control and Rehabilitation is directing a study of Diethylstilbestrol (DES) exposure of females *in utero*. The DESAD project deals with DES-associated vaginal adenosis and cervical irregularities.

The physicians of the DESAD Project Professional and Public Relations Subcommittee have compiled a pamphlet concerning this problem. "Information for Physicians—DES Exposure *in Utero*" was edited by the Office of Cancer Communications of the National Cancer Institute and is available without cost to physicians. The pamphlet considers the specific cancer problem related to DES exposure, non-cancerous irregularities which have occurred, and the advised treatment methodology. A listing of DES-type drugs which may have been prescribed for pregnant women is included, as well as a complete bibliography.

Two additional pamphlets are available at no charge for distribution to concerned patients. "Were YOU OR YOUR DAUGHTER Born after 1940?" is a short leaflet designed to encourage DES-exposed daughters to seek examination. "Questions and Answers About DES Exposure Before Birth" is a more thorough patient-oriented report, intended for those in whom DES exposure has been confirmed.

Any physician who might come into contact with women whose mothers may have been treated with DES or chemical compounds of a similar nature are urged to write for copies of these pamphlets. The materials may be obtained from the Office of Cancer Communications, Department IL, Building 31, Room 10A19, National Cancer Institute, NIH, Bethesda, Md. 20014.

### LOW-COST GROUP INSURANCE ANOTHER ISMS MEMBERSHIP PRIVILEGE

FOR INFORMATION,  
ASSISTANCE  
& DETAILS CONTACT:

Administrators:

**PARKER, NICHOLSON & COMPANY**  
ESTABLISHED 1901  
*Insurance*

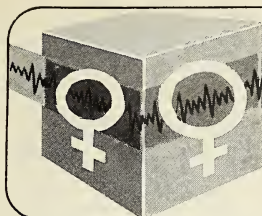
**THE GROUP DISABILITY PLAN** ● Provides up to \$1,732.00 monthly in the event of disability caused by Accident or Sickness. ● Special Guaranteed renewal feature. ● Protect your income and security.

**BUSINESS OVERHEAD EXPENSE PLAN** ● Pays your office overhead expense when disability strikes. ● Premiums are Tax Deductible. ● Pays in Addition to the Disability Plan Benefits.

**THE BASIC MAJOR MEDICAL EXPENSE PLAN** ● In or out of Hospital Benefits up to \$25,000.00 per Disability. ● Up to \$100.00 Daily Hospital Room and Board maximum. ● Subject to choice of deductible and 80% coinsurance.

**EXCESS MAJOR MEDICAL PLAN** ● Provides up to \$250,000 for Medical Expenses. ● Supplements any Basic Major Medical Plan and has a \$25,000 deductible. ● Low group rates. ● Truly catastrophic coverage.

9933 N. Lawler Avenue  
Skokie, Illinois 60076  
Phone: 312-679-1000



## *pulse... of the doctor's wife*

Mrs. HAROLD KEEGAN, Editor

### ***Combined District Meeting***

Districts 3 and 11 of the ISMS Auxiliary met Tuesday, November 9, 1976, at the Hyatt Regency Hotel in Chicago. Mrs. Jack D. Clemis, president of the Chicago Medical Society Auxiliary, introduced the district councilors, Mrs. Herbert Cibul, 3rd district councilor and Mrs. Eugene Dach, 11th district councilor.



**L to R, Maria Arocha, Kankakee and Dale Dach, District 11 Councilor.**

Mrs. Mary Ann Cook, an attorney with the law firm of Jenner and Block, who has practiced in Chicago for 15 years, spoke about "A Woman and Her Money." Mrs. Cook covered the "do's and don'ts" in estate planning. She stated that



**L to R, Joy Zimmerman, DuPage County Auxiliary President, Grace Simonaitis, DuPage County Auxiliary President-elect and Eunice O'Donnell, Director of ISMS Aux.**

it is important for physicians' wives to be aware of the details of their husbands' estates, as well as the procedure to follow, and who to contact in the event of a death.

After the luncheon a second speech was presented by Mr. Mortimer Enright, of the American Medical Association. The title of his program was "Me! In Front of a Group." Mr. Enright gave the "how to's" of public speaking and followed his presentation with a question and answer session.

#### **Attention Members-At-Large**

You have recently received your new dues envelope. Please realize that you are a valuable link in the auxiliary chain. Take a moment now, fill out your envelope and mail with your dues to our MEMBERS-AT-LARGE Chairman, Mrs. Paul P. David (Rose) 1100 Cambridge Ave., Flossmoor, Illinois 60622.

The "Health Careers Planning Guide" by Carl Runkel of the University of Illinois, is now available to all county auxiliaries. Mrs. Don Hinderliter, chairman of Health Education and Health Manpower, stated that the book is very comprehensive on health career planning. County auxiliaries may purchase the book. Please contact Mrs. Don Hinderliter, 1113 Tilton Park Drive, Rochelle, Illinois 61068, phone 815-562-7728.

## Physician Recruitment Program

*In an effort to reduce the number of towns in Illinois needing physicians, the Physician Recruitment Program and the Doctor's Job Fair, are publishing synopses in the Journal.*

*Physicians who are seeking a place to practice or who know of any out-of-state physicians seeking an Illinois residence are asked to notify the Program.*

*Any areas wishing to be listed should contact: Mrs. E. Duffy, Physician Recruitment Program, ISMS, 55 E. Monroe, Suite 3510, Chicago, 60603.*

**ARCOLA:** F.P. or G.P. needed to join only physician in true rural community (2,300 population). Must be willing to do O.B. Ultimate plans for new 3-man clinic. Close to beautiful county hospital less than 10 years old. Robert N. Arrol, M.D., 126 S. Locust, Arcola, Illinois, 61910. (217) 268-4444 or (217) 268-4404. (3)

**BLOOMINGTON:** Two active Internists seek Family Practitioners and Pediatricians to join evolving private group of primary-care practitioners. Group to consist of six physicians leasing office space in hospital-owned building. Organized within a Community Health Center setting. Contact: Michael Daniloff, Vice-President, Professional Services, Mennonite Hospital, 807 North Main Street, Bloomington, 61701 (309) 828-5241. (3)

**CARBONDALE:** Family physician: innovative neighborhood health center in southern Illinois seeks Family Practice Physician to provide patient care and supervise other professionals, para-professionals in clinic setting. Salary negotiable. Position available October 1976. Write: Robert Stalls, Director of Human Resources, City of Carbondale, 602 E. College Street, Carbondale, Illinois 62901, (618) 549-5302. (2)

**CHAMPAIGN:** General Internist, Pulmonary Medicine, Allergist, Oncologist/Hematologist, Rheumatologist, Family Practitioner, Dermatologist, Neurologist, Urologist and ENT opportunities in 31-man multispecialty, youth-oriented group. Guaranteed salary leading to early Associateship with future income based on individual productivity. Medium sized, Big-10 University community. Contact Mr. Arthur H. Perkins, Administrator, Christie Clinic, 104 West Clark Street, Champaign, 61820 (217) 351-1200. (3)

**CHESTER:** The Menard Correctional Center is presently searching for an Illinois Licensed physician, GP or IM. Duties will include daily sick call, admission physicals and histories, daily rounds in institution medical unit and segregation unit. Salary dependent upon training and experience, and fringe benefits including malpractice insurance. Write: Cecil Patmon, Administrator, Medical Services, 160 North LaSalle, Room 425, Chicago 60601, or call collect 312-793-3216. (4)

**CHICAGO:** Medical center N.W. Side of Chicago with clinical laboratory, X-rays, physical therapy. 2 Family Physicians, members A.A.P.F., looking for a young, well trained, ambitious F.P. Privileges in hospital with Department of Family Practice. Contact: F. Steinitz, M.D., 3653 W. Lawrence, Chgo. 60625, 312-478-6000. (2)

**CHICAGO:** Staff Pathologist with a desire to develop new clinical laboratory procedures and work with an innovative specialized medical staff, needed to join our progressive university-affiliated Chicago hospital. Must be certified/eligible in clinical and anatomic pathology and interested in teaching. Excellent salary and benefit program. Write or call: Nancy Siegel, Staffing Specialist, Louis A. Weiss Memorial Hospital, 4646 North Marine Drive, Chicago, 60640, (312) 769-2162. (3)

**CLINTON:** Population 8500. Opening for solo general practice. Four physicians in General Practice at present. Twenty-five miles from Decatur and Bloomington. Office available. Recreational facilities excellent. Clinton Nuclear Power Plant under construction 6 mi. east of City. Contact: M. J. Hein, 422 West White, Clinton 61727, AC 217-935-3171. (2)

**DANVILLE:** Need Primary Care Physicians. Also Neurologist(s) and/or Neurosurgeon(s). Population 43,000. Service Area 180,000. Excellent schools, near university. Contact R. V. Livengood, Lakeview Medical Center, Danville, 61832 (217) 443-5201. (3).

**HARVEY:** General Practitioner or Family Practitioner opening available in our practice. Practice in the Chicago area and in the south suburb. Good pay and benefits. Interested parties please contact 333-1411 or P.O. Box 677, Harvey, 60426. (3).

**JUSTICE:** One or two good Family Practitioners needed: lovely new medical center (southwest), on-site surgery center, X-ray, laboratory, emergency room and pharmacy; complete staff 15 doctors for various specialties who are on staff at nearby 500 bed hospital. Opportunity for future partnership. Contact Dr. E. I. Breslar, Forest Hill Medical Center, 9050 W. 81st, Justice 60458. 312-594-3500. (2)

**McHENRY:** We have openings available for Board Certified or eligible OB-GYN, Ped., Int. Med./Card. and Orthopaedic physicians on the staff of our 23 physician multispecialty group. Incentive pay from day one with minimum guaranteed draw, malpractice paid, partnership after 1-2 years, excellent fringe benefits. We are 55 miles northwest of Chicago in the Chain-o-Lakes resort area. The medical group is physically adjacent to a 147 bed general community hospital and State Trauma Center. Jim Dickson, Personnel Director, McHenry Medical Group, McHenry 60050. (815-385-1050 ext. 332). (2)

**OLNEY:** ENT, Internal Medicine, Dermatology, Ophthalmology needed. 26 MD multispecialty partnership, 15,000+ referral population, new bldg., 1st yr. earnings guaranteed, 200 bed modern hospital, 4 wks. vacation, 2 wks. meeting per yr. Contact: David L. Potter, Adm., Weber Medical Clinic, 1200 N. East St., Olney 62450 (618) 395-4311. (2)



**ORLAND PARK:** Orland Park and far S.W. Chicago office, need general practice physicians, complete facilities both offices. New office bldg. completed Dec. 1, 1976. Contact: C. E. Cornelison, Adm., 10444 S. Kedzie, Chicago 60655, (312) 239-3000. (4)

**PINCKNEYVILLE:** Population 3500—Serves an area of 20,000. Medical group partnership of four physicians seeking fifth member. Complete office facilities—2 blocks from fully accredited hospital. Salary one year—then partnership. Good recreational facilities—near St. Louis. Contact: Clarence E. Cawvey, M.D., 206 North Main Street, Pinckneyville 62274 Phone: 618-357-2131. (2)

**ROCHELLE:** Population 10,000—Two primary care physicians needed. Hospital serves an area of approximately 20,000. Acute general 68-bed hospital with full services, including physical and respiratory therapies. Office space available adjacent to hospital. Located 25 miles from Rockford and a medical college, 17 miles from major university, and an hour-and-a-half from Chicago. Excellent schools, parks and civic organizations. Contact Administrator, Rochelle Community Hospital, 900 North 2nd Street, Rochelle 61068 (815) 562-2181. (2)

**ROCKFORD:** Opening for Board eligible Internist in multi-specialty group of Internists. Brand new building; two minutes from large, modern hospital. Near Rockford School of Medicine—part time teach opportunities if desired. Guaranteed income with full partnership after one year. 90 miles NW of Chicago on I-90. CONTACT: T. R. Glatzer, M.D., 5670 E. State St., Rockford 61108. 815-398-4040 or 815-877-0096. (2)

**SANDWICH:** General Practice Physicians. Substantial annual guarantee, plus office facilities. 50 miles west of Chicago. Additional physicians are needed due to recent illness of one physician and death of another. Modern 92 bed hospital. Contact: President, Sandwich Community Hospital, 11 E. Pleasant St., Sandwich, 60548 or Phone 815-786-8484. (3)

**SPRINGFIELD:** Emergency physician needed to supplement existing department in 650 bed community hospital with medical school affiliation. New emergency department facilities, 50,000 visits per year, excellent salary and fringe benefits, 40-44 hour week. Teaching position available if desired. Involvement with ongoing MERCY communications net and paramedic training program. Excellent opportunity to work, teach, and live in progressive midwest community with a metropolitan area of approximately 150,000. Contact E. W. Donelan, M.D., Chairman Emergency Services, St. John's Hospital, 800 East Carpenter, Springfield, 62702, 217-544-6464. (3).

**WAYNE CITY:** Thriving community located in Wayne County in southern-most Illinois. Office facilities furnished for young Family or General Practitioner. No physicians in this community. Contact: Grant Smith, President, First National Bank, Wayne City 62895; 618/895-2118. (2)

## ILLINOIS STATE MEDICAL SOCIETY

Invites You On an

# Alps·Riviera Adventure

to

SWITZERLAND—ITALY—FRANCE



Departing Chicago on June 28, 1977  
and returning July 11, 1977

**\$1398**

Join us for a two-week, do-as-you-please holiday in the heart of Europe. Enjoy deluxe hotels and fine restaurants. See the spectacular snow-capped Alps and charming Lausanne on Lake Geneva. Experience the Renaissance grandeur of Florence's art and architecture. Relax with the jet set on the French Riviera of Nice, Cannes and Monte Carlo.

A deluxe trip with direct-flight convenience at charter-cost savings. Don't miss it. Send your deposit today.

Send to: Illinois State Medical Society  
55 East Monroe  
Chicago, Illinois 60603

Enclosed is my check for \$\_\_\_\_\_ (\$100 per person) as deposit.

Name(s) \_\_\_\_\_

Home Address \_\_\_\_\_

City \_\_\_\_\_

State \_\_\_\_\_

Zip \_\_\_\_\_

Another Non-Regimented **INTRAV** Deluxe Adventure



★  
*Specialized Service*

IN  
PROFESSIONAL LIABILITY INSURANCE

*is a high mark of distinction*

**THE  
MEDICAL PROTECTIVE COMPANY**

**FORT WAYNE, INDIANA**

*Professional Protection Exclusively since 1899*

CHICAGO AREA OFFICE:

T. J. Pandak, J. C. Kunches, L. R. Gannan, and W. G. Prangle, Representatives  
814 Commerce Drive, Suite 101B, Oak Brook, Illinois 60521 (312) 325-7314

SPRINGFIELD OFFICE: W. J. Nattermann, Representative

426½ South Fifth Street, Springfield 62701 (217) 544-2251

# Treat yourself to a day, a week end or an entire week!

This week get away from it all! Lake Lawn Lodge has the restful atmosphere you need to unwind. Call Milwaukee (414) 342-7939 for reservations, or call or write us directly.



## LAKE LAWN LODGE

Box M, Delavan, WI 53115  
Phone 414/728-5511



Blue Cross®  
Blue Shield®



# REPORT

## FOR *Illinois Physicians*

### Coordination of Benefits

Coordination of Benefits is a group contract provision designed to limit the combined payment of health care programs to no more than the total covered charges incurred. Most Blue Cross-Blue Shield groups and employer insurance programs now incorporate this provision in their contracts.

Our Plan is in agreement with most other health benefit underwriters on certain basic rules in determining which carrier will have primary liability when two or more coverages are involved and either or both have coordination of benefit provisions:

(1) The health care plan in which the patient is insured has the primary responsibility. The spouse's group plan has secondary responsibility for health care costs not covered by the primary carrier.

(2) When a dependent child receives care, the father's group plan, provided he has a family plan, has primary responsibility.

(3) When the patient is covered under two group plans as an employee, the plan under which he has been covered for the longest time is considered primary.

Health care plans which an employee or member of the employee's family purchase as an individual (not through a group) are not affected by the COB provisions outlined above.

It is the responsibility of the insurance carriers to determine the extent of liability of the companies or Plans involved. Providing as much information as possible to each carrier about other coverage in force will shorten this process, reduce correspondence and prevent unnecessary delays in payment of benefits.

### Concurrent Medical Care

Additional benefits would be paid under most Blue Shield certificates for concurrent medical care when a patient is admitted to a hospital primarily for surgical or obstetrical care, if (1) care was rendered by a physician other than the surgeon or obstetrician (2) unusual circumstances required it and (3) *the specialized medical care was essential to and distinct from the surgical or obstetrical care.* Allowances vary according to the type of Blue Shield certificate held by the member.

Examples of eligible claims for concurrent medical care are:

(1) The patient develops a post-operative condition requiring specialized medical services. In such cases, the physician rendering medical care should bill Blue Shield from the date he enters the case to the date of completion of his hospital service.

(2) The patient has a medical condition requiring close supervision both pre and post-operatively. In this case, the physician should bill Blue Shield for the entire period of hospitalization and describe in detail the condition of the patient.

(3) The patient is admitted as a medical patient and treated medically for a period before being transferred to the surgical or obstetrical service. In such cases, the physician rendering medical care should bill Blue Shield for his service to the date of transfer.

(4) The patient is primarily a medical patient and the surgery performed is a minor procedure or diagnostic in nature. In these cases the physician rendering medical care should bill Blue Shield for the entire period of hospitalization.

Admission date, discharge date, diagnosis and the number of in-hospital daily visits made must be reported before claims can be paid. To avoid returning reports for additional information, the question on the Blue Shield Physician's Service Report must be completed, e.g. "Was surgery also performed," and "If so, by whom?", even if all services performed were medical.

In most Blue Shield certificates, payment for in-hospital medical care is limited to one visit per day.

### Date of Accident Needed on Physician's Service Reports

Most Blue Shield contracts provide benefits for emergency care of accidental injuries which do not require an operative procedure, such as treatment of sprains, contusions or abrasions.

To avoid delay in processing claims, the *date of the accident* must be shown on the Physician's Service Report.

## Signature of Patient Necessary on Medicare Forms

The Medicare SSA 1490 form is a legal government form and therefore subject to the signature requirements specified by the Department of Health, Education and Welfare.

The signature of a patient is an essential part of the Medicare form. Not only is the signature a verification that the services being billed for were actually rendered, but it authorizes the physician, or any holder of medical or other information, to release whatever information is necessary to process the claim. The signature also is a request for payment to be made to the patient himself or to the physician who has accepted the assignment.

There are certain instances where a patient's signature is not necessary; these are listed below:

- (1) When a physician is accepting the assignment and the patient is a Public Aid (Medicaid) recipient, the IDPA number must be shown in Item 5 of the SSA 1490 form. Instead of a signature, the form may state "Public Aid Recipient," or a similar statement.
- (2) If the patient is deceased, and the physician is accepting the assignment, the physician may simply write "Patient Deceased" in Item 6. If the physician is not accepting the assignment, the name and address of the next of kin or of the person who paid the bill should appear in this space.
- (3) A patient who is incapable of signing his name, due to illiteracy or physical handicap, may sign with a mark (X). This must be witnessed. The patient's name and the signature and address of the witness must be shown in Item 6.
- (4) If a patient is physically or mentally unable to transact business, a relative, guardian, or friend of the patient may sign for him. Item 6 should show the patient's name, the name of the person signing in his behalf, and the relationship of that person to the patient. For example, "Joe Smith by Helen Jones, daughter."
- (5) The administrator of a non-profit residential home may sign for the patient if he has the patient's power-of-attorney. Item 6 should show "Joe Smith by Adam Marks, Administrator, Home."
- (6) A physician, or an employee of the physician, cannot sign on behalf of the patient except under extraordinary circumstances. When there is NO ONE else to sign for the patient, documentation must be shown that the patient is unable to sign and a full explanation must be given as to why there is

no other person available who could sign on his behalf.

- (7) No third party agreements or special forms made up by a physician or clinic can be accepted. A statement such as "Signature on File," "Signature in Medical Records," or a similar statement is not acceptable; nor is a copy of an admission form, consultation report, or surgery report. Although these forms serve as proof that a service was rendered, they do not authorize payment to be made.

In cases where a patient has a prolonged illness or a condition which requires treatment for a specific period of time, the patient may sign the following authorization; but a copy of this authorization **MUST BE ATTACHED** to each Medicare form submitted by the physician during that particular period of time:

"I request that payment under the medical insurance program be made either to me or to Dr. \_\_\_\_\_

(name of physician)

on any bills for services furnished me by that physician during the period from \_\_\_\_\_ to \_\_\_\_\_.

Signed \_\_\_\_\_  
name of patient)

The period should end no later than the close of the calendar year during which the authorization is made, unless the authorization is made during October, November, or December, in which case it would be at the end of the following year.

## SSA Changes in Laboratory Certifications

Notice was received from the Bureau of Health Insurance, Social Security Administration, of the following closings of laboratories participating in the Medicare program.

No payment can be made under the health insurance program for services rendered on or after the effective closing date:

Mediscreen Laboratory, Eight South Michigan Ave., Rm. 1620, Chicago 60603 (Provider Number 14-8219) closed, effective October 1, 1976.

3940 Clinical and X-ray Laboratory, 3940 West Division Street, Chicago 60651 (Provider Number 14-8305) closed, effective July 27, 1976.

McGregor Laboratories, 6144 West Roosevelt Road, Oak Park (Provider Number 14-8144) closed, effective November 1, 1976.

100 mg

250 mg

500 mg



# **Tolinase<sup>®</sup>** tolazamide, Upjohn

Please contact your Upjohn representative for additional product information.

**Upjohn**

J-5595-6

© 1977 THE UPJOHN COMPANY





# Editorials

## Legal Rights vs. Patient Needs

All Illinois physicians should be aware of the serious implications of the recently published report of the Governor's Commission to Revise the Mental Health Code. The long-awaited report, produced after three years at a cost of \$300,000, would revise substantially the 1967 Mental Health Code if enacted. Senator John Nimrod (R., Skokie), Chairman, Illinois Mental Health Commission, already has called two public hearings on the issue. Further hearings are expected. Legislative proposals derived from the report probably will be introduced in the 1977 General Assembly.

Although some revisions of the 1967 Code were necessary, the report's generally legalistic orientation has created great concern among the state's psychiatrists and other physicians. Under a controversial provision dealing with admission and discharge requirements, for example, physicians examining involuntary patients would be required to administer a "Miranda-type" warning, i.e., inform the patient that his comments subsequently may be used against him during commitment hearings. This would, in effect, place a physician in the role of a policeman arresting a criminal, a role that all physicians would consider abhorrent. Another provision would severely limit involuntary hospitalization only to the *physically dangerous person* who presents an *immediate* threat to himself or others. This stipulation would deprive treatment to thousands of mentally ill Illinois citizens. In states with unreasonably stringent commitment laws, highly-publicized tragedies have occurred involving mentally ill individuals desperately in need of treatment, but turned away from hospitals because their illness did not fulfill narrow legal criteria. Similar incidents might be expected in Illinois if the Commission's proposals are enacted.

Other proposed revisions further intrude on the physician's clinical judgment by enumerating detailed restrictions on the use of restraints, seclusion and psychotropic drugs. In addition, seri-

ously-disturbed patients would be permitted to refuse any type of hospital treatment, including medication, unless immediate physical danger is evident. These revisions will lead only to delaying vital care, increasing hospital cost, and exposing other patients and staff to physical injury.

Implementation of some of the report's recommendations would establish dangerous precedents for all medical practices. Issues of concern to all physicians include unnecessary restrictions on voluntary patients in private facilities and the granting of hospital admission privileges to non-physicians. Although recent newspaper publicity has favored the use of so-called "qualified examiners" (i.e., clinical psychologists, psychiatric social workers and psychiatric nurses) in the initial admission process, ISMS and Illinois Psychiatric Society representatives repeatedly have emphasized the danger of using lesser trained personnel in the evaluation of a patient's need for hospitalization.

We are concerned, also, about the proposed establishment of a legal advocacy system, which would not only divert scarce fiscal resources from direct patient care, but would place yet another intermediary between the physician and his patient. By ignoring the physician's primary function as a patient advocate, the Commission has introduced an unnecessary adversarial element into the treatment process, and greatly increased the malpractice risk for physician and hospital.

The Commission consistently has ignored recommendations by practicing physicians who treat the mentally ill in favor of viewpoints expounded by civil libertarians. Involuntary hospitalization should not be capricious. It should not be so restrictive, however, that sick people are prevented from obtaining treatment. Illinois physicians should urge their legislators to take a serious look at the proposed revisions and develop a more rational balance between a patient's legal rights and his need for appropriate treatment.

Alex J. Spadoni, M.D., President  
Illinois Psychiatric Society

# CLEAR THE TRACT

For coughs of colds,  
"flu" and u.r.i.—  
clear the tract  
with the famous  
Robitussin® Line!

The 5 members of the Robitussin® family all contain the expectorant, guaifenesin, to help clear the lower respiratory tract. Guaifenesin works systematically to help stimulate the output of lower respiratory tract fluid. This enhanced flow of less viscous secretions promotes ciliary action and makes thick, inspissated mucus less viscous and easier to raise. As a result, dry, unproductive coughs become more productive and less frequent.

For productive and unproductive coughs

## Robitussin®

Each 5 ml teaspoonful contains:  
Guaifenesin, NF ..... 100 mg  
Alcohol, 3.5%

For severe coughs

## Robitussin A-C®

Each 5 ml teaspoonful contains:  
Guaifenesin, NF ..... 100 mg  
Codeine Phosphate, USP ..... 10.0 mg  
(warning: may be habit forming)  
Alcohol, 3.5%

Non narcotic for 6-8-hour cough control

## Robitussin-DM®

Each 5 ml teaspoonful contains:  
Guaifenesin, NF ..... 100 mg  
Dextromethorphan  
Hydrobromide, NF ..... 15 mg  
Alcohol, 1.4%

Decongests nasal passages and sinus  
openings as it helps relieve coughs

## Robitussin-PE®

Each 5 ml teaspoonful contains:  
Guaifenesin, NF ..... 100 mg  
Pseudoephedrine  
Hydrochloride, NF ..... 30 mg  
Alcohol, 1.4%

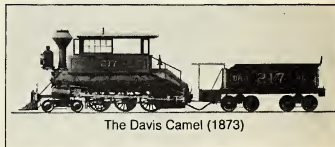
Decongestant action helps control cough and  
clear stuffy noses and sinuses. Non narcotic.

## Robitussin-CF®

Each 5 ml teaspoonful contains:  
Guaifenesin, NF ..... 50 mg  
Phenylpropanolamine  
Hydrochloride, NF ..... 12.5 mg  
Dextromethorphan  
Hydrobromide, NF ..... 10 mg  
Alcohol, 1.4%

All Robitussin formulations available on your  
Rx or Recommendation.

For many years Robins has spotlighted the expectorant action of the Robitussin cough formulations by featuring action photographs of steam engines like the one on the preceding page. In keeping with this tradition, last year the company commissioned a well-known illustrator to render full-color drawings of several classic locomotives... accurate to the minutest detail. Chances are you requested and received the first locomotive in this series, The William Mason, last winter. Now, the second one is available. (See below). To order your print suitable for framing, write "Robitussin Clear-Tract Engine #2" on your Rx pad and mail to "Vintage Locomotives," Dept. T4, A. H. Robins Company, 1407 Cummings Drive, Richmond, Va. 23220.



The Davis Camel (1873)

OUR PHOTO: Norfolk & Western Branch Train  
No. 202 west bound near Alvarado, Va. (Oct., 1956).  
This line reaches the highest point of any railroad  
East of the Rockies (elevation 9,577 ft.) with a  
minimum grade of 3%. It crosses 108 bridges,  
some 700 ft. long! Photo by O. Winston Link.

A-H ROBINS

A. H. Robins Company, Richmond, Va. 23220

# **ISMS LEADERSHIP CONFERENCE**

Saturday, March 19, 1977

Marriott Motor Hotel  
(Near O'Hare Airport)

8535 W. Higgins Road  
Chicago

County medical society officers and executives, as well as ISMS and AMA delegates, are invited to participate in an issue-oriented forum on such current topics as:

## **MEDICAL DISCIPLINE**

The role of peer review and the focus of continuing medical education for today's physician.

## **HEALTH PLANNING**

Problems and issues confronting local HSA's; How HSA actions will affect your practice.

## **LEGISLATION**

Pending legislation affecting physicians; IMPAC as the physicians' tool; ISMS Key Man Program.

## **MALPRACTICE**

Activities of the ISMS Task Force on Professional Liability; Countersuit update; Status of ISMIE.

When making your reservation, please specify that you are a participant of the ISMS Leadership Conference. Hotel accommodations for the Conference are available to you at a special group rate.



# If your angina patient\* isn't having 3 out of 4 better days than usual... try Cardilate® (ERYTHRITYL TETRANITRATE)

\*Please note: unstable angina patients may be refractory to all long-acting nitrates

**INDICATIONS:** For the prophylaxis and long-term treatment of patients with frequent or recurrent anginal pain and reduced exercise tolerance associated with angina pectoris, rather than for the treatment of the acute attack of angina pectoris, since its onset of action is somewhat slower than that of nitroglycerin.

**PRECAUTIONS:** As with other effective nitrates, some fall in blood pressure may occur with large doses.

Caution should be observed in administering the drug to patients with a history of recent cerebral hemorrhage, because of the vasodilatation which occurs in the area. Although therapy permits more normal activity, the patient should not be allowed to misinterpret freedom from anginal attacks as a signal to drop all restrictions.

**SIDE EFFECTS:** No serious side effects have been reported. In sublingual therapy a tingling sensation (like that of nitroglycerin) may sometimes be noted at the point of tablet contact with the mucous membrane. If objectionable, this may be mitigated by placing the tablet in the buccal pouch. As with nitroglycerin or other effective nitrites, temporary vascular headache may occur during the first few days of therapy. This can be controlled by temporary dosage reduction in order to allow adjustment of the cerebral hemodynamics to the initial marked cerebral vasodilatation. These headaches usually disappear within one week of continuous therapy but may be minimized by the administration of analgesics.

Mild gastrointestinal disturbances occur occasionally with larger doses and may be controlled by reducing the dose temporarily.

**SUPPLIED:** 10 mg chewable tablets, bottle of 100. Also 5, 10 and 15 mg scored tablets in bottles of 100. 10 mg scored tablets also supplied in bottle of 1,000.

Also available: Cardilate® P brand Erythrityl Tetranitrate with Phenobarbital\* (\*Warning: may be habit-forming).

1. Russek HI: AM J M Sc 239:478, 1960



**"Pain days" significantly reduced with Cardilate®** (erythrityl tetranitrate) in 48-patient study.<sup>1</sup> Patients on placebo experienced same pain as usual or increased pain 2 days out of 3... compared to 1 day out of 4 while on Cardilate.

**Rapid-acting chewable tablets** (10mg) preferred by many patients. Should be given before anticipated periods of stress to produce an action within 5 minutes and lasting up to 2 hours. Sublingual tablets also available.



**Effective prophylaxis against attacks;** increases exercise tolerance. Serious side effects have not been reported in 20 years' clinical use.

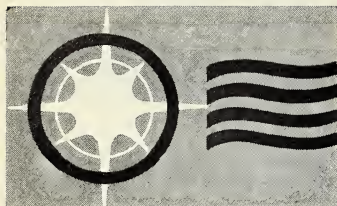
**Cardilate can save patients money;** is less expensive than many popular long-acting nitrates. 20% to 30% savings not uncommon...also helps reduce need for nitroglycerin.



Wellcome

Burroughs Wellcome Co.  
Research Triangle Park  
North Carolina 27709





## membership forum

### *Response to the Chicago Tribune Editorial:*

#### *"Radiologists Fees"*

The *Tribune's* recent editorial on radiologists shows an unfortunate lack of understanding of how radiologists practice their profession, and unfairly accuses many honorable and dedicated physicians as having "money-grubbing" attitudes. Of course radiologists administrate and operate radiology services in hospitals; if the *Tribune* wishes to describe that as a monopoly, it is their journalistic prerogative. But it is difficult for me to imagine anybody wishing to have his X-ray examination conducted and interpreted by anyone who has had no special training in radiology.

Charges for specific X-ray examinations vary as much as 50% throughout the local area, probably more than do charges for most other goods and services. These charges are available, for the asking, at every hospital and radiology office. Most of the radiology practiced is on an out-patient basis, and therefore patients can compare charges before undergoing examinations.

I, like most radiologists, am very concerned about the rising cost of medical care. But we radiologists do not establish the prices of the newer technologically advanced equipment, we do not order the many unnecessary X-rays done as a result of the practice of "defensive medicine," we do not determine the exorbitant cost of malpractice insurance, and we do not control the salaries of our employees.

Radiologists do earn good incomes, but so do other professionals, corporation executives, plumbers, certain salesmen, brokers, and persons in all walks of life. As long as a free enterprise system is maintained in this country, radiologists are as entitled to comfortable incomes just as much as all others. Should the day come when all professionals and self-employed persons have their incomes and working conditions dictated to them by government, it will not only be the radiologist who loses something precious, but it will be every American as well.

Leonard Berlin, M.D., *Radiologist*

# THERE ARE A LOT OF PEOPLE GETTING BETWEEN YOU AND YOUR PATIENT.

Medicine today is in the spotlight, subjected to all kinds of scrutiny. Your control over patient therapy is being monitored, judged and occasionally abrogated, sometimes by unknown third parties.

The worry is that in the wake of this focus, the relationship between you and your patient will be weakened, without offsetting benefits. Consider three examples:

**Drug substitution** In most states, pharmacy laws, regulations or professional custom stipulate that your non-generic prescriptions be filled with the precise products you prescribe. But in the last five years, a dozen or more State laws have been changed, permitting the pharmacist in most cases to select a product of the same generic drug to fill any prescription.

Ironically, this dilution of physician control has taken place against a background of growing evidence that purportedly equivalent drug products may be inequivalent, since neither present drug standards nor their enforcement are optimal. In fact, the FDA itself says it has not enforced the same standards for hundreds of "follow-on" products that it had applied to the original NDA approvals. Thus physician control over patient therapy is being eroded with a risk that patients may be exposed to drugs of uncertain quality.

The major advertised claim for substitution is reduced prescription prices for consumers. Yet no documentation of any significant savings has been produced.

**MAC** Maximum Allowable Cost, MAC for short, is a Federal regulation designed to cut the Government's drug bill by setting price ceilings for drugs dispensed to Medicare and Medicaid patients. Unless the prescriber certifies on the prescription that a particular product is medically necessary, the Government intends to pay only for the cost of the lowest-priced, purportedly-equivalent,

generally-available product. The effect of the program may be that elderly and indigent patients will be restricted to products which someone in Washington believes are priced right. Practicing doctors will have little to say about administration of the program, since Government will have absolute authority to make its choices stick.

**The drug lag** The future of drug and device research depends upon a scientific and regulatory environment that encourages therapeutic innovations. The American pharmaceutical industry annually is spending more than \$1 billion of its own funds and evaluating more than 1,200 investigational compounds in clinical research. Disease targets include cancer, atherosclerosis, viruses and central nervous system disorders, among others. But there is a major barrier to the flow of new drugs to your patients: The cost of the research is more than ten times what it was, per product, in 1962; and whereas governmental clearance of new drug applications took six months then, it commonly consumes two years now.

The FDA needs adequate time, of course, to consider data. But it is equally clear that the present approval process contributes to needless delay of needed therapy. That's why the increased efficiency of the drug approval process is vital to all our futures.

If these issues concern you, we suggest that you make your voice heard—among your colleagues and your representatives in State legislatures and in Washington.

It could make a difference in your practice tomorrow.



Pharmaceutical Manufacturers Association  
1155 Fifteenth Street, N.W., Washington, D.C. 20005

## ILLINOIS STATE MEDICAL SOCIETY

**INTRAV.**

### Around The World Adventure

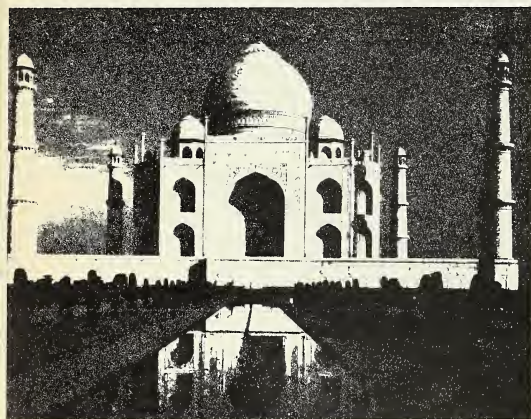
The Ultimate Travel Experience. A 34 day trip to:  
Tokyo, Hong Kong, New Delhi, Agra, Kabul,  
Cairo, Istanbul,

Jerusalem, Tel Aviv, and London

**DEPARTING CHICAGO AND ST. LOUIS — SEPTEMBER 5, 1977  
RETURNING OCTOBER 8, 1977**

Here is a deluxe non-regimented trip that takes you to the exotic lands of the world. You'll circle the globe following the sun with almost all daylight flights. You'll visit eight fascinating countries with time to unpack and relax.

Around The World Adventure... the most exciting and personally enriching travel experience of your lifetime... an outstanding quality trip for \$4995.  
Don't miss it.



Send to: Illinois State Medical Society  
55 East Monroe  
Chicago, Illinois 60603

Check one  
Departing —  
☐ Chicago  
☐ St. Louis

Enclosed is my check for \$ \_\_\_\_\_ (\$200 per person) as deposit.

Name(s) \_\_\_\_\_ (LAST) (FIRST) (SPOUSE)

Home Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

A Non-Regimented **INTRAV** Deluxe Adventure

## Obituaries

\*Arp, Louis C., Moline, died January 2 at the age of 81. Doctor Arp was a 1923 graduate from Minnesota.

\*Bard, Ruben, Chicago, died December 21 at the age of 74. Doctor Bard was a 1926 graduate of the University of Illinois.

\*Bobbitt, Robert L., Zion, died December 6 at the age of 55. Doctor Bobbitt was a 1945 graduate of the University of Pennsylvania.

\*Capps, Richard B., Chicago, died December 25 at the age of 70. Doctor Capps was a 1931 graduate of Harvard.

\*Culbertson, Roy F., East St. Louis, died September 25th at the age of 68. Doctor Culbertson was a 1934 graduate of Washington University.

\*Gregg, William L., Chicago, died December 13 at the age of 92. Doctor Gregg was a 1907 graduate of the University of Illinois.

\*Kelly, Tim H., Homewood, died December 11th at the age of 70. Doctor Kelly was a 1931 medical school graduate from Greighton, Omaha.

\*Lindman, Martin C., Rockford, died December 18th at the age of 68. Doctor Lindman was a 1935 graduate of Northwestern University.

\*Nash, Herbert T., Chicago, died December 19th at the age of 75. Doctor Nash was a 1928 graduate of the University of Illinois.

\*Peele, Bernard T., Chicago, died December 12th at the age of 58. Doctor Peele was a 1944 graduate of the Stritch School of medicine.

\*Shapiro, Benjamin B., Skokie, died December 18th at the age of 88. Doctor Shapiro was a 1925 graduate of Cincinnati Medical School.

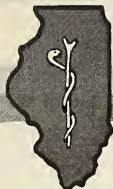
\*Towle, Gilbert A., Chicago Heights, died September 9th at the age of 63. Doctor Towle was a 1942 graduate of Loyola University.

\*Weinstock, Irma, Chicago, died in November of last year at the age of 82. Doctor Weinstock was a 1922 graduate from Berlin, Germany.

\*Indicates ISMS member.

\*\*Indicates member of the ISMS Fifty Year Club.





## report

Illinois Society  
American Association of Medical Assistants

# AAMA to Offer Continuing Education Credits

By PAT PARKS, CMA-A

The Continuing Education Committee of the American Association of Medical Assistants has announced that its program for awarding Continuing Education Unit (CEU) credit for qualified educational programs is now underway. This program has been established in response to the tremendous interest in self-improvement on the part of medical assistants in the areas of education and professionalism. Also of considerable bearing are the pressures of increasing malpractice claims, the demand for high-quality health care and government interest in the fields of medicine and allied health.

To be considered for CEU credit, a medical assisting educational program must conform to the following criteria:

1. The content of the program must pertain to the practice of medical assisting;
2. The program must be at least one hour in length and must be presented in an organized, effective learning format;
3. The learning objectives must be defined in

specific behavioral terms;

4. The instructor must be well qualified;
5. Participant learning must be assessed; and
6. The program must be evaluated by participants.

Illinois Society is in the process of planning several educational seminars at which time CEU credit will be offered. Please watch this page for further information regarding these programs and for registration forms.

Our organization of over 900 members in Illinois is dedicated to the continued educational advancement of medical assistants, and this new program by our national office is expected to greatly enhance the professionalism of medical assistants.

For further information regarding membership in this worthwhile organization please contact First Vice President, Mrs. Velma Hukill, 115 N. Fourth Street, Cuba, IL. 61427 or 2nd Vice President, Mrs. Jean Nelson, 829 Carnaby Court, Schaumburg, IL. 60172.



# Do you have patients with Paget's Disease of Bone?



You can get updated information on the disease and on effective treatment for its symptoms of bone pain, skeletal deformities, and neurologic deficits.

Just send the coupon below.



Armour Pharmaceutical Company  
Greyhound Tower  
111 West Clarendon Avenue  
Phoenix, Arizona 85077

- ☐ Send latest information on Paget's Disease of Bone.  
☐ Have your representative call on me.

Dr. \_\_\_\_\_

Address \_\_\_\_\_

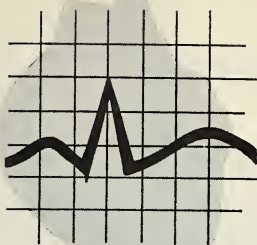
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

## Clinics for Crippled Children Listed for March

Thirty-four clinics for Illinois' physically handicapped children have been scheduled for March by the University of Illinois, Division of Services for Crippled Children. The Division will count twenty-five general clinics providing diagnostic orthopedic, pediatric, speech and hearing examination, along with medical, social and nursing services. There will be eight special clinics for children with cardiac conditions and one for children with cerebral palsy. Any private physician may refer to or bring to a convenient clinic any child or children for whom he may want examination or consultative services.

- March 1 Carrolton, Boyd Memorial Hospital
- March 2 Carmi, Carmi Township Hospital
- March 2 Hinsdale, Hinsdale Sanitarium
- March 2 Elgin, Sherman Hospital
- March 3 Sterling, Community General Hospital
- March 3 Effingham, St. Anthony Memorial Hospital
- March 3 Lake County Cardiac, Victory Memorial Hospital
- March 4 Division Cardiac, U. of I. at the Medical Center
- March 8 East St. Louis, Christian Welfare Hospital
- March 8 Peoria, St. Francis Hospital
- March 9 Champaign-Urbana, McKinley Hospital
- March 9 Joliet, St. Joseph's Hospital
- March 9 Chicago Heights General, St. James Hospital
- March 10 Springfield, St. John's Hospital
- March 10 Macomb, McDonough District Hospital
- March 11 Chicago Heights, Cardiac, St. James Hospital
- March 14 Peoria Cardiac, St. Francis Hospital
- March 15 Belleville, St. Elizabeth's Hospital
- March 15 Rock Island, Moline Public Hospital
- March 15 Decatur, Decatur Memorial Hospital
- March 16 Springfield Pediatric-Neurology, St. John's Hospital
- March 16 Centralia, St. Mary's Hospital
- March 16 Evergreen Park, Little Company of Mary Hospital
- March 17 West Frankfort, Union Hospital
- March 17 Elmhurst Cardiac, Memorial Hospital of DuPage County
- March 21 Maywood, Loyola Medical Center
- March 22 Alton, Alton Memorial Hospital
- March 22 Peoria, St. Francis Hospital
- March 22 Park Ridge Cardiac, Lutheran General Hospital
- March 23 Rockford, St. Anthony's Hospital
- March 23 Chicago Heights General, St. James Hospital
- March 23 Elgin, Sherman Hospital
- March 25 Chicago Heights Cardiac, St. James Hospital
- March 28 Peoria Cardiac, St. Francis Hospital

The Division of Services for Crippled Children is the official state agency established to provide medical, surgical, corrective and other services and facilities for diagnosis, hospitalization and after-care for children with crippling conditions or who are suffering from conditions that may lead to crippling. In carrying on its program, the Division works cooperatively with local medical societies, hospitals, the Illinois Children's Hospital-School, civic and fraternal clubs, visiting nurse association, local, social and welfare agencies, local chapters of the National Foundation and other interested groups. In all cases the work of the Division is intended to extend and supplement, not supplant activities of other agencies, either public or private, state or local, carried on behalf of crippled children.

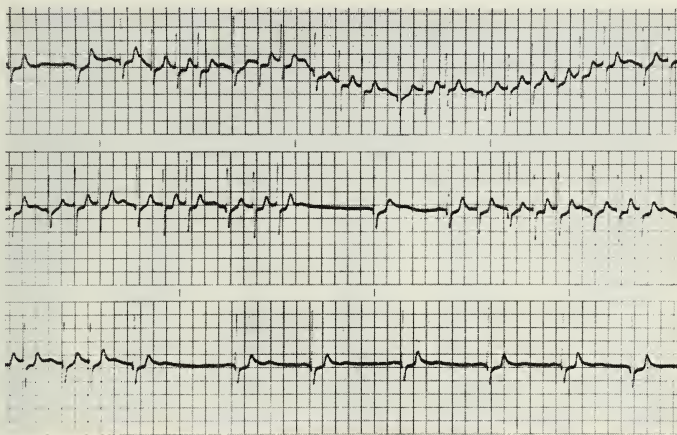


## ekg of the month

JOHN R. TOBIN, JR., M.S., M.D., RIMGAUDAS NEMICKAS, M.D.,  
PATRICK J. SCANLON, M.D., JOHN F. MORAN, M.S., M.D.,  
SARAH JOHNSON, M.D., and ROLF M. GUNNAR, M.S., M.D./  
Section of Cardiology, Department of Medicine,  
Loyola University Stritch School of Medicine

A forty-eight-year-old woman presented because of intermittent palpitations which were accompanied by dyspnea and feelings of weakness. She had had short episodes of palpitations previously, but they had never required treatment. She had a history of rheumatic fever at age 12 but had no cardiovascular symptoms

throughout her life until now. This included three uneventful pregnancies. Examination of the heart was difficult because of the rate, but an opening snap and diastolic rumble murmur were thought to be present. An ECG rhythm strip was obtained and is shown.



### Questions:

#### 1. The ECG shows:

- Proxysmal atrial flutter.
- Paroxysmal atrial tachycardia (reciprocating or re-entry).
- Paroxysmal atrial fibrillation.
- Non-respiratory sinus arrhythmia.
- Varying P wave contours.

#### 2. This rhythm disturbance is commonly seen in patients with:

- Coronary heart disease, hypertensive cardiovascular disease, acute myocardial infarction.
- Rheumatic heart disease; thyrotoxicosis.
- Cardiomyopathy, myocarditis, pericarditis, pulmonary embolism.
- Rheumatic heart disease, especially involving the mitral valve.
- All of the above. (*Answers on page 112*)

**contains no aspirin**

tablets

**Darvocet-N<sup>®</sup> 100**

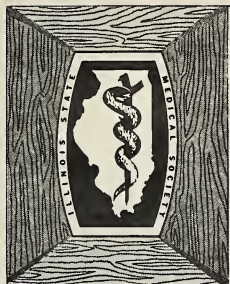
100 mg. Darvon-N<sup>®</sup> (propoxyphene napsylate)  
650 mg. acetaminophen

**100**

*Lilly*

Additional information available  
to the profession on request.  
Eli Lilly and Company, Inc.  
Indianapolis, Indiana 46206

700043



# I M J

*Illinois Medical Journal*

Vol. 151, No. 2, February, 1977

## EFFECTIVE TREATMENT OF DIABETIC RETINOPATHY

BY PETER H. MORSE, M.D./CHICAGO

Diabetic retinopathy results from a slowly progressive ischemia which damages the retina and consequently the vision of many patients. It is the leading cause of adult new blindness in the United States today.

Background retinopathy, such as microaneurysms and other microvascular changes which leak plasma resulting in retinal edema and hard yellow exudates in the macula, frequently underlie a decrease in a patient's central vision. These minimal ophthalmoscopic changes are often overlooked or ascribed to some other cause, such as cataract.

Neovascular or proliferative diabetic retinopathy is more insidious in that it may be far advanced with maintenance of 20/20 visual acuity. This is often the tragic case in juvenile diabetics who note no difficulty until they have a hemorrhage in the eye which impairs their vision. Once this has occurred, the proliferative new blood vessels may be so far advanced that they are more difficult to treat successfully and require a much more rigorous and prolonged course of therapy for the patient.

Both types of retinopathy may coexist in an

eye and there may be a marked difference in type and extent between the two eyes of any patient.

Early examination, treatment, and continuous follow-up of all diabetic patients by an ophthalmologist is essential. The pupils must be dilated and the ocular fundus must be carefully examined in every case using direct and indirect ophthalmoscopy and a highly magnified biomicroscopic technique in many instances.

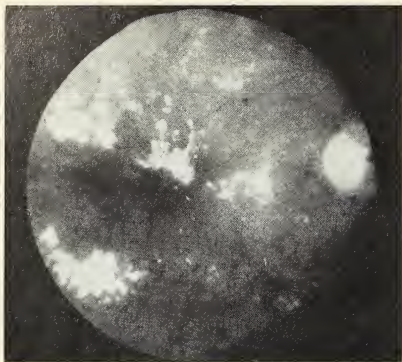
Early photocoagulation is an effective method of preventing total blindness in most diabetic patients.

In the patient with chronic leaking microvascular changes near the macula, one sees the microaneurysms surrounded by retinal edema and hard yellow exudates. The Argon laser with its small treatment spot size (50, 100 microns) and its greater wavelength absorption by hemoglobin is used to directly burn these leaking microvascular lesions. After healing, the edema and hard yellow exudates reabsorb and the vision usually stabilizes and sometimes improves (Figures 1 & 2). This technique of treatment will often prevent a marked loss of central vision.<sup>1</sup>

The degree of success of this treatment may vary depending upon the presence of significant cataract, other macular pathology such as macular degeneration or cystoid changes, the duration of macular edema and hard yellow exudate, and the presence of severe hypertension or renal failure. One especially important prognostic factor

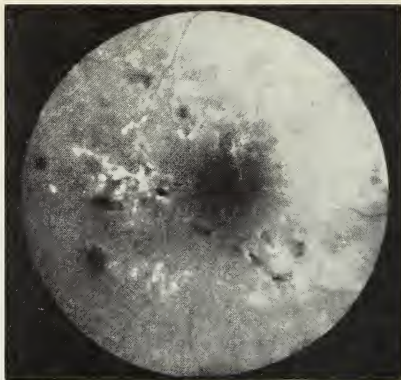
**PETER H. MORSE, M.D.**, is an associate professor in the department of ophthalmology at the University of Chicago Hospitals and Clinics, Pritzker School of Medicine. He is a former fellow of the Heed Ophthalmic Foundation in Chicago and also the Retina Service, Massachusetts Eye and Ear Infirmary, Boston.





**Figure 1**

Fundus photograph of a patient with microvascular abnormalities, retinal edema, and hard yellow exudates, markedly interfering with central vision.



**Figure 2**

Same patient as in Figure 1 after treatment with the Argon laser and healing. There has been a dramatic clearing of central vision.

is the extent and location of infarction of the retinal vessels which has occurred in the natural history of diabetic retinopathy. Cotton wool patches or "soft exudates" are commonly seen in diabetics even without coexisting hypertension. These cotton wool patches are infarcts in the retinal nerve fiber layer which may irreparably damage central vision if they occur too close to the macula. Microaneurysms commonly surround these areas of infarction, which appear as zones of capillary nonperfusion or avascularity on fundus fluorescein angiography.<sup>2</sup>

Neovascular proliferative diabetic retinopathy threatens the patient with total blindness from vitreous hemorrhage or secondary retinal detachment.<sup>3</sup> These new vessels arise as endothelial budding from the vessels within the retina and initially spread on the retinal surface. As the fibrovascular tissue proliferates, it may attach to the posterior vitreous surface and with vitreous contraction or posterior vitreous separation result in a hemorrhage or retinal detachment. The rate of progression of these new blood vessels is variable and unpredictable, so that early treatment gives the patient the best chance of avoiding future complications.

The majority of the wavelengths of any photocoagulation system are absorbed by the pigmented epithelium of the retina and the radiated heat creates a thermal burn which obliterates the new

blood vessels after healing. A greater amount of radiated heat is absorbed by the vessels lying flat on the retinal surface, facilitating their obliteration. The heat created by photocoagulation may cause a contraction of the fibrovascular tissue and posterior separation of the vitreous either or both of which may lead to vitreous hemorrhage and retinal separation. This may be very unfavorable in cases of advanced, elevated fibroproliferative retinopathy. Vessels elevated above the retinal surface, after closure at the time of treatment, have a predisposition to reopen which makes their complete obliteration more difficult.

### Early Treatment Stage

In early cases of neovascular diabetic retinopathy, the patches of new blood vessels may be focally obliterated with photocoagulation and the patient observed carefully at intervals. When new blood vessels arise directly from the optic nerve head, an ablative, panretinal photocoagulation or scatter method is usually preferred.<sup>4</sup> The theory behind this method of treatment is the selective destruction of a certain volume of retinal tissue without extensive loss of visual field. The hypoxic retinal areas, presumably stimulating new blood vessel formation, are rendered anoxic and the volume of retinal tissue demanding oxygenation is reduced. This method of panretinal photocoagulation has proven effective.

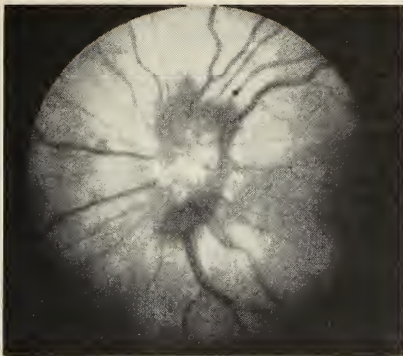


Figure 3

Fundus photograph of a patient with neovascular tissue arising from the optic nerve head which had bled into the vitreous.

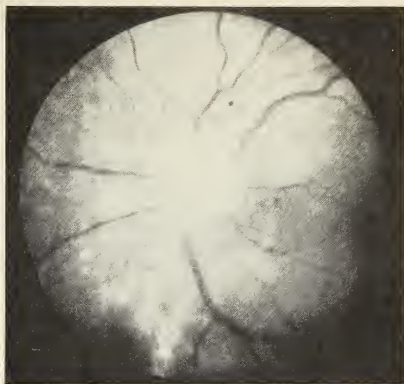


Figure 4

Same patient as in Figure 3 after panretinal photocoagulation which effected an involution of the new blood vessels.

tive in 40-60% of patients with new blood vessels on the optic nerve head (Figures 3 & 4).<sup>5-7</sup>

Panretinal photocoagulation may be combined with focal treatment in cases of extensive peripheral diabetic neovascular retinopathy.

All patients must be periodically evaluated and retreated if there is any recrudescence of neovascularization.

If vitreous hemorrhage does not spontaneously clear, or if fibrovascular membranes interfere with the visual acuity, the patient may need surgical vitrectomy. This operation removes vitreous debris and fibrovascular membranes. In some in-

stances, fibrous membranes distorting or exerting traction on the retina may be peeled from the retinal surface or otherwise cut to release the traction. This procedure has restored useful vision in a number of patients previously considered blind.<sup>8</sup>

It must be emphasized that early examination and treatment of diabetic patients provides them with the best chance of preventing incapacitating blindness. If used at the proper time in the evolutionary course of diabetic retinopathy, photocoagulation offers a simple and effective treatment for an otherwise hopeless problem. ◀

## References

1. Patz, A., Schatz, H., Berkow, J. W., Gittelsohn, A. M., and Ticho, U.: "Macular Edema—An Overlooked Complication of Diabetic Retinopathy," *Trans. Amer. Acad. Ophthalm. and Otolaryngol.* 77:Op. 34-42, 1973.
2. Ticho, U. and Patz, A.: "The Role of Capillary Perfusion in the Management of Diabetic Macular Edema," *Amer. J. Ophthalm.* 76:880-886, 1973.
3. Patz, A.: "Visual Prognosis in Advanced Diabetic Retinopathy," U.S. Public Health Service Symposium on the Treatment of Diabetic Retinopathy, Publication #1890, Sept. 1968.
4. James, W. A. and L'Esperance, F. A.: "Treatment of Diabetic Optic Nerve Neovascularization by Extensive Retinal Photocoagulation," *Amer. J. Ophthalm.* 78:939-947, 1974.
5. Beetham, W. P., Aiello, L. M., Balodimos, M. C., and Koncz, L.: "Ruby Laser Photocoagulation of Early Diabetic Neovascular Retinopathy," *Arch. Ophthalm.* 83: 261-272, 1970.
6. Zweng, H. C., Little, H. L., and Peabody, R. R.: "Further Observations of Argon Laser Photocoagulation of Diabetic Retinopathy," *Trans. Amer. Acad. Ophthalm. and Otolaryngol.* 76:990-1004, 1972.
7. L'Esperance, F. A.: "Argon Laser Photocoagulation of Diabetic Retinal Neovascularization (A Five Year Appraisal)," *Trans. Amer. Acad. Ophthalm. and Otolaryngol.* 77:Op. 6-24, 1973.
8. Michels, R. G., Macheimer, R., and Mueller-Jensen, K.: "Vitreous Surgery: History and Current Concepts," *Ophthalm Surg.* 5:13-59, 1974.

# RHEUMATOID MYOPATHY

BY PAUL E. KAPLAN, M.D./CHICAGO

*Rheumatoid myopathy may well be an intense and focal process involving the muscles of patients with rheumatoid arthritis. It may have an uncertain course with many exacerbations and remissions. This review of research and data examines pertinent theory on the subject.*

The nature of myopathy associated with rheumatoid arthritis has been obscure. This is a sharp contrast to the stark picture of a patient's limb after deformity and muscular atrophy have deprived it of function. Many authors (among them Horwitz<sup>1</sup> and Kestler<sup>2</sup>) have described the small round cell infiltration and muscle fiber destruction at first thought to be specific for rheumatoid myositis. However, Clawson<sup>3</sup> and Bunim<sup>4</sup> have studied routine autopsy cases and have demonstrated lesions identical to the rheumatoid myositis nodules in control populations. The conclusion was that the lesions were much more common in populations of rheumatoid patients than in control patients.

Morrison<sup>5</sup> correlated data from electromyographic and post-mortem examinations. The research found that 17 out of 34 patients with rheumatoid arthritis had involuntary, regularly occurring diphasic action potentials. Discrete inflammatory lesions were found in muscles and peripheral nerves, but no specific lesions were found in the central nervous system. Peterson<sup>6</sup> found two cases of decreased duration of action potentials in atrophied first dorsal interosseous muscles of rheumatoid patients. Gradual and Hvid<sup>7</sup> demonstrated spontaneous action poten-

tials in 15 of 22 rheumatoid patients. In addition, 60% of 31 arthritis patients (including those with rheumatoid arthritis, psoriatic arthritis, and ankylosing spondylitis) had action potential durations of two to three milliseconds in first dorsal interosseous muscles and in a scattering of other muscles. Myopathic histology was correlated with decreased action potential durations and fasciculation potentials in rheumatoid arthritis patients.

Hauge<sup>8</sup> found fibrillation potentials in five rheumatoid patients irrespective of the presence of muscular atrophy. None of these patients had been involved with steroid therapy. No nerve conduction study data was given. In 79 of 93 rheumatoid arthritis patients, Steinberg and Wynn Parry<sup>9</sup> demonstrated evidence of denervative potentials and myositic action potentials (polymyositic electromyographic changes). Both proximal and distal muscles were sampled. Intensity duration curves revealed partial denervation was present in 37 muscles with polymyositic electromyographic changes. Again, there was no relationship between steroid therapy and the electromyographic changes. Motor nerve conduction time was normal in all 10 cases where it was performed. Rossel<sup>10</sup> studied 50 rheumatoid patients using the biceps brachii in all but two of the patients. He noted that 16% of the patients had decreased duration of action potentials and 72% had myositis interstitialis nodularis. The research found no relation between the lesion found at muscle biopsy and steroid therapy. Therefore, although myopathy was very common in rheumatoid populations and not related to steroid therapy, the relationship to possible neuropathy was not clear.

Moritz<sup>11</sup> published very detailed studies of rheumatoid myopathy. The two populations

---

PAUL E. KAPLAN, M.D., is an assistant professor in the department of rehabilitation medicine, chairman of the graduate committee and faculty senate member at the Northwestern University School of Medicine. Dr. Kaplan is a rehabilitation physiatrist and a fellow of the Academy of Physical Medicine and Rehabilitation. He is a member of the Memorial Hospital committee on renal disease and transplant, and both the infectious disease committee and the pharmacology and therapeutics committees at the Rehabilitation Institute.



used were a control group and a study group of patients with classical and definite rheumatoid arthritis according to the criteria of the American Rheumatism Association. He also included five patients with disuse atrophy in the control group and six patients with systemic lupus erythematosus in the study group. The five cases with disuse atrophy were shown to have normal duration action potentials. In the study group, 21 out of 82 patients were taking steroids. Both distal and proximal muscles were studied electromyographically, especially the first dorsal interosseous and the biceps brachii. Fifty-five percent of the rheumatoid cases and all lupus cases had reduced duration of action potentials without any relation to steroid therapy. Of 34 cases with normal action potential duration, 18 showed increased numbers of polyphasic potentials. Decreased action potential duration and/or increased insertional activity were found more frequently in the intrinsic hand muscles and in all muscles near joints actively involved with rheumatoid arthritis. Moreover, nerve conduction velocity studies were normal in the study group, and a loss of functioning muscle fibers within motor units was demonstrated. Wasserman<sup>12</sup> studied 16 patients with classical or definite rheumatoid arthritis according to American Rheumatism Association criteria. He examined both distal and proximal muscles of the upper and lower extremities. Six patients had taken steroid treatment. Polyphasic potentials and/or fibrillation potentials were noted in 13 of the 16 patients, and were particularly common in distal muscles. Abnormal chronaxie determinations were also much more common in the distal muscles. In addition, six of the patients had abnormal nerve conduction velocity values, including a total of eight extremities involved with rheumatoid arthritis. Although more evidence was obtained on the electromyographic manifestations of a myopathy in rheumatoid patients, the additional presence of a neuropathy was a possibility, particularly in Wasserman's population. There have been papers tending to refute the concept of rheumatoid myositis as a separate entity.

### Further Studies

Mueller and Mead<sup>13</sup> found that spontaneous involuntary activity in muscles of rheumatoid patients could be stopped consistently by proper positioning of the joints. Amick<sup>14</sup> found normal elbow to wrist conduction times for the ulnar nerve in 25 patients with rheumatoid arthritis.

The action potentials produced were of normal duration. He concluded that the atrophy seen in rheumatoid arthritis was due to disuse atrophy. Yates<sup>15</sup> studied 34 patients with active classical arthritis according to criteria of American Rheumatism Association. Electromyographies and punch biopsies were used to study the deltoid and quadriceps muscles. The majority of the myopathic changes were found in patients being treated with steroid therapy. In the 18 cases where the patient was not on steroid therapy, no specific abnormality was found.

Rheumatoid myopathy has also been studied for chemical changes. Wegelius<sup>16</sup> demonstrated an increased creatine-creatinine ratio in their rheumatoid myopathy study. Muscle biopsies revealed foci of lymphocytes and degradation of contractile elements. It is significant that creatine phosphokinase and transaminase levels were normal. The suggestion was made that these results were compatible with a benign lesion of either inflammatory or immobilization etiology.

Earlier Hart et al<sup>17</sup> established the presence of peripheral neuropathy in patients with rheumatoid arthritis. Studies by Mason and Steinberg<sup>18</sup>, Ferguson and Slocumb<sup>19</sup> and Steinberg<sup>20</sup> further documented rheumatoid neuropathy. The full variety of neuropathic manifestations were described. In particular, a mild sensorimotor peripheral neuropathy and entrapment neuropathies were discussed. Weller, Bruckner, and Chamberlain<sup>21</sup> also presented rheumatoid patients with a mild distal sensory neuritis. Varying degrees of axonal degeneration in large myelinated fibers were also noted.

### Focal Inflammation Process

The hypothesis most consistent with the preceding studies would be an intense and focal inflammatory process. This myositis may affect only a few of the muscle fibers in a given muscle. The resulting inflammation would be subacute with exacerbations and remissions. Thus, the natural history could explain the conflicting data. Many questions center on which of the processes influence the course and the extent of the inflammation. Steroid therapy, a mild peripheral neuropathy, and disuse atrophy can all alter the course of any myositis. A well controlled prospective study of the natural history of rheumatoid myopathy in patients not on steroid therapy is needed. Histologic, electromyographic, nerve conduction, intensity-duration, and chemical data would be needed and should be correlated to distal or proximal muscles and



to the proximetry to involved joints. **In the last analysis, the total effect of a rheumatoid myositis may well be produced by inflammatory processes in muscles working with the inflammatory processes in the peripheral nerves.**

The best way to document this situation would be to reduce each set of data to numbers; that is, stages of muscle inflammation by histology, quantitative measurements of the interference pattern produced by the muscle, nerve conduction measurements, levels of enzymatic activity. These numbers could be correlated and descriptive profiles plotted using digital computers. Optimally, a large number of patients would be located in more than one medical center. A population of healthy volunteers and another of patients with neuropathy could be matched with the rheumatoid population for age and sex and used as control populations.

### Ongoing Research

Certain recent studies have tended to support this hypothesis. One of these compared the muscle biopsy abnormalities in patients with rheumatoid diseases and polymyositis as well as patients with polymyalgia rheumatica. Patients with classical rheumatoid arthritis had muscle biopsy abnormalities as noted above. Only one of the patients with classical rheumatoid arthritis was taking steroids at the time of biopsy. In the patients with the more severe type of rheumatoid arthritis, that is ARA stage III and stage IV, there was a group of patients with changes in fiber size, atrophy of type I fibers, and no atrophy of type IIB fibers. This contrasted with the less severe patients with stage II and stage III rheumatoid arthritis who did show type IIB fiber atrophy as demonstrated by histochemical techniques. As the type IIB fiber atrophy is often seen in disuse atrophy, a more distinctive process may have been evident in the patients with more severe rheumatoid arthritis. In a situation consistent with an active myositis condition<sup>22</sup> a patient with rheumatoid arthritis presented an active skeletal and myocardial myopathy with an elevated SGOT<sup>23</sup>. Finally, the metabolic rate of the turnover IgG has been studied in a group of patients with various connective tissue diseases such as systemic lupus erythematosus, rheumatoid arthritis, polymyositis, vasculitis, and other miscellaneous diseases. The turnover rate of IgG elevated in 11 out of 16 patients with systemic lupus erythematosus, 8 out of 9 with rheumatoid arthritis, and 4 out of 5 with polymyositis as well as all 5 of

the patients with vasculitis. Fractional catabolic rates were also increased and the results all consistent with a selective hypercatabolism of IgG.<sup>24</sup>

A group of patients with rheumatoid arthritis and various systemic sequela were studied with motor-point biopsy techniques. Two groups of patients with active myopathies were delineated, one with chronic myopathy and another with myositis. It was noted that the cellular nodules found in muscle tissue were probably clinically significant, especially when they were profuse and associated with various significant pathological changes such as a great deal of cellular infiltration, necrosis, and regeneration or muscle cachexy.<sup>25</sup> This kind of a pathologic study could be more directly correlated with immunologic and neurophysiological inquiries in the future so as to present the type of comprehensive study that this complex process demands. ◀

### Acknowledgement

We are deeply grateful to Miss Elizabeth Henery for her help in producing this manuscript.

### References

1. Horwitz, M.: "Muscle Lesions in Rheumatoid Arthritis," *Ann. Rheum. Dis.* 8:258, 1949.
2. Kestler, O. C.: "Histopathology of Intrinsic Muscles of Hand in Rheumatoid Arthritis," *Ann. Rheum. Dis.* 8: 42, 1949.
3. Clawson, B. J., Noble, J. F., and Lufkin, N. H.: "Nodular Inflammatory and Degenerative Lesions of Muscles from Four Hundred and Fifty Autopsies," *Arch. Path.* 43:579, 1947.
4. Bunim, J., Sokoloff, L., Wilens, S. L., and McEwen, C.: "Cellular Aggregates in Skeletal Muscle of Patients with Rheumatic Diseases Other than Rheumatoid Arthritis," *Ann. Rheum. Dis.* 7:251, 1948.
5. Morrison, L. R., Short, C. L., Ludwig, A. O., and Schwab, R. S.: "Neuromuscular System in Rheumatoid Arthritis," *Am. J. of Med. Sci.* 124:33, 1947.
6. Petersen, I.: "An Electromyographic Study of the Atrophied First Dorsal Interosseous Muscle in Rheumatoid Arthritis," *Acta Physio. Scand.* 1:67-72, 1955.
7. Graudal, H., and Hvid, N.: "An Electromyographic Study in Patients With Arthritis," *Acta Rheum. Scand.* 5:34-41, 1959.
8. Hauge, T.: "Electromyographic Investigations in Rheumatoid Arthritis," *Acta Rheum. Scand.* 6:287-296, 1960.
9. Steinberg, V. L. and Wynn Parry, C. B.: "Electromyographic Changes in Rheumatoid Arthritis," *Brit. Med. J.* 1:630, 1961.
10. Rossel, I.: "An Electromyographic and Histologic Study of Muscles in Rheumatoid Arthritis," *Acta Rheum. Scand.* 9:65-78, 1963.

11. Moritz, U.: "Electromyographic Studies in Adult Rheumatoid Arthritis," *Acta Rheum. Scand. Supplement* 6:1-123, 1963.
12. Wasserman, R. R., Oster, Y. T., Oryshkevich, R. S., Montgomery, M. M., Poske, R. M., and Ruksha, A.: "Electromyographic, Electrodiagnostic, and Motor Nerve Conduction Observations in Patients with Rheumatoid Arthritis," *Arch. of Phys. Med. & Rehab.* 49:90, 1968.
13. Mueller, E. E. and Mead, S.: "Electromyogram in Rheumatoid Arthritis," *Am. J. Phys. Med.* 31:67, 1952.
14. Amick, L. D.: "Muscular Atrophy in Rheumatoid Arthritis, An Electrodiagnostic Study," *Arth. Rheum.* 3:54-63, 1960.
15. Yates, D. A. H.: "Muscular Changes in Rheumatoid Arthritis," *Am. Rheum. Dis.* 22:342, 1963.
16. Wegelius, O., Pasternack, A., and Kuhlback, B.: "Muscular Involvement in Rheumatoid Arthritis," *Acta Rheum. Scand.* 15:257-261, 1969.
17. Hart, F. D., Golding, J. R., and Mackenzie, D. H.: "Neuropathy in Rheumatoid Disease," *Ann. of the Rheum. Dis.* 16:471, 1957.
18. Mason, R. M., and Steinberg, V. L.: "Rheumatoid Arthritis," *Ann. Phys. Med.* 4:265, 1958.
19. Ferguson, R. H., and Slocomb, C. H.: "Peripheral Neuropathy in Rheumatic Arthritis," *Bull. of Rheum. Dis.* 11:251-254, 1961.
20. Steinberg, V. L.: "Neuropathy in Rheumatic Disease," *Brit. Med. J.* 1:1600, 1960.
21. Weller, R. O., Bruckner, F. E., and Chamberline, M. A.: "Rheumatoid Neuropathy: A Histologic and Electrophysiological Study," *J. Neur. & Neurosurg. and Psych.* 33:592-6004, 1970.
22. Brooke, M. H. and Kaplan, H.: "Muscle Pathology in Rheumatoid Arthritis, Polymyalgia Rheumatica and Polymyositis," *Arch. Path.* 94:101, 1972.
23. Castaigne, P., Escourolle, R., Brunet, P., Hauw, J. J., Ricou, P., and Truelle, J. L.: "Determinations Inflammatoires Nerveuses et Musculaires, Squelettiques et Myocardiques, au cours d'une Maladie Rheumatoide," *Ann. Med. Interne* 125:177, 1974.
24. Wochner, R. D.: "Hypercatabolism of Normal IgG: an Unexplained Immunoglobulin Abnormality in the Connective Tissue Diseases," *J. Clin. Invest.* 49:454, 1970.
25. Haslock, D. I., Wright, V., and Harriman, D. G. F.: "Neuromuscular Disorders in Rheumatoid Arthritis," *Quant. J. of Med., New Series* XXXIX:335, 1970.

★

*Specialized Service*

IN

PROFESSIONAL LIABILITY INSURANCE

*is a high mark of distinction*

**MEDICAL PROTECTIVE COMPANY**

**FORT WAYNE, INDIANA**

*Professional Protection Exclusively since 1899*

CHICAGO AREA OFFICE:

T. J. Pandak, J. C. Kunches, L. R. Gannon, and W. G. Prangle, Representatives  
 814 Commerce Drive, Suite 101B, Oak Brook, Illinois 60521 (312) 325-7314

SPRINGFIELD OFFICE: W. J. Nattermann, Representative  
 426½ South Fifth Street, Springfield 62701 (217) 544-2251

# Pseudomonas Lumbar Diskitis

BY ABDUL R. C. AMINE, M.D., AND JOSE L. SALAZAR, M.D./CHICAGO

In the last decade attention to the late delayed medical sequela of drug addiction has been increased. Almost all systems may be involved in these complications, which are rare but serious.

Skin abscess, hepatitis, endocarditis, brain abscess, transverse myelitis, septic phlebitis, pneumonia, pneumothorax, pulmonary embolism, pulmonary vascular occlusive disease and soft tissue necrosis, may occur when drugs are injected into blood vessels.<sup>1-9</sup> Osteomyelitis and disc infection are also reported, as in the following case.

## Case Report

A woman, 45-years-old, was admitted to the hospital as a victim of a robbery attempt in which she sustained injuries of the back when she was kicked and thrown to the ground.

Because of the severity of back pain, she was unable to stand immediately following the incident, but she was able to walk after a few hours. The pain was localized to the lumbo-

sacral area without radiation into the lower extremities. She denied any past history of back pain similar to the chief complaint.

The patient had been a drug (heroin) addict until 1969, but she admitted excess intake of alcohol since. She had had asthma since 1956.

Physical examination on admission showed a pale, poorly nourished woman; weight 56kg, height 152 cm, temperature 36.0°C, pulse 70/min., blood pressure 86/50mm Hg. Needle marks over both arms and legs were present. The remainder of the general physical examination was unremarkable except for a few basal rales in both lungs.

Neurological examination revealed exquisitely tender lumbar-sacral spine on palpation, particularly at L<sub>4</sub> and L<sub>5</sub>. Straight leg raising was painful at 20° on both sides. Motor examination was not fruitful because of poor cooperation due to pain. Sensory examination showed questionably decreased pin prick on the lower extremities up to the groins. Vibration and position sense were intact. There was a decreased left knee jerk, without pathological reflexes.

X-ray films of the lumbar sacral area revealed narrowing of the L<sub>4</sub>-L<sub>5</sub> intervertebral disc space, and irregularity and destruction of the inferior border of L<sub>4</sub> and superior border of L<sub>5</sub>, with associated sclerotic changes (Fig. 1, 2). There was no paravertebral soft tissue mass. Bone scan with Tc 99m (disodiummetidronate) showed localized increased pickup at the L<sub>5</sub> level. Electromyography of the lower extremities revealed multiphasic potentials, and denervation potentials in lower back muscles from L<sub>4</sub>-S<sub>1</sub>. Nerve conduction velocities of the lower extremities were normal.

## Laboratory Data

Serology test for syphilis was non-reactive. Sedimentation rate was 55/1 hour. Tuberculin tests with medium strength PPD was negative



ABDUL R. C. AMINE, M.D., is an instructor in neurological surgery at the Abraham Lincoln School of Medicine and also a full time staff member in the division of neurosurgery at Cook County Hospital.



JOSE L. SALAZAR, M.D., is an attending neurosurgeon at the Illinois Masonic Medical Center and former director of the microneurosurgery laboratory, Neuropsychiatric Institute, at the University of Illinois Medical Center.

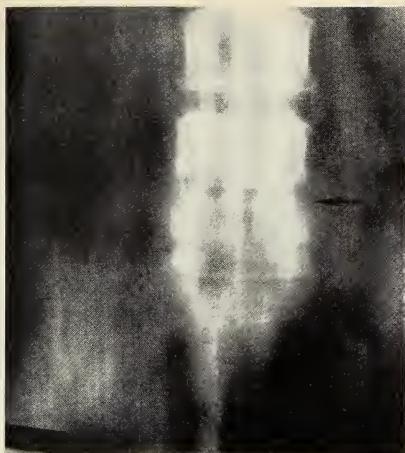


Figure 1

Antero-posterior tomogram of lumbar spine shows collapsed L4-5 disc space (arrow) irregular, and destroyed adjacent margins of L4 and L5 are with minimal sclerotic changes.

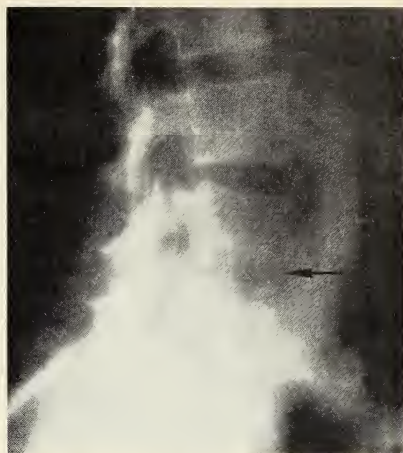


Figure 2

Lateral tomographic x-ray view illustrates the irregular margins, collapsed disc space, and bony destruction (arrow) in contrast to the disc spaces above and below.

24+48 hours. The Mantoux test was reactive (20 mm diameter erythema in 48 hours). Blood counts:

WBC	6.4	
PMN	66%	
LYMPH	25%	
RBC		
(millions)	3.34	
GH (gm)	10.8	
MCV normal		
(82-92mu/ml)	99	
MCH normal		
(27-31uu.gm)	32.5	
Reticulocyte counts	2.0%	
Platelet count	162,000	normal (145,000-375,000)
Serum Folic acid	0.6 mg/ml	normal (4-16)
Vit B <sub>12</sub>	529 pg/ml	

Alkaline phosphatase 125 units (normal 30-85), total serum protein was 6.5gm%. Protein electrophoresis showed, gamma globulin elevated to 25% and elevated alpha 2 ( $\alpha$ 2) to 13.7%. The albumin globulin ratio was 1/1.

Biopsy was done from the L<sub>4-5</sub> disc space and the adjacent bone, using a Silverman needle under general anesthesia. Culture showed *Pseudomonas aeruginosa*. Culture for acid-fast bacil-

lus was negative after six weeks, and no fungi were seen on the culture media. Histological studies of biopsy material showed spicules of bone and granulation tissue with acute and chronic inflammation.

Hospital course: The curve of the temperature was never higher than 37°C (98.6°F). The blood pressure was never more than 90/60 mm Hg. The patient was started on Gentamycine, 80 mgm I.M. every 8 hours; Carbenicillin was later added (5 gm every 4 hours).

## Discussion

Diskitis as described in the case report is not a frequent complication of drug addiction. The most frequent organisms have been *staphylococcus aureus*, *streptococcus*, *candida* species, *escherichia coli*, *aerobacter aerogenes*, and *pseudomonas aeruginosa*.<sup>1,6,7,9</sup> The radiologic features in this case are similar to the ones described by Salahuddin, et al,<sup>7</sup> in their seven cases, as well as by others.<sup>2,4,9</sup>

The appearance of *pseudomonas aeruginosa* diskitis and chondro-osteomyelitis in this case six years following cessation of drug habit is a phenomenon peculiar to this gram-negative bacillus, which is known to be a common skin



contaminant. Blood culture was not done, as such cases are not expected to have positive culture; however positive blood cultures are frequently present in cases with endocarditis.<sup>1</sup>

Drug related diskitis appears most commonly in lumbar region<sup>2,6,9</sup> as in our case (L<sub>4</sub>-L<sub>5</sub>). Two cases have been reported outside the lumbar spine.<sup>2,4</sup>

Most cases reported in the literature concerned individuals who had been heroin addicts for some time and were still "shooting". Our case is peculiar in that the lesion was not brought to the patient's attention until the traumatic incident, about six years after "kicking the habit." This indicates the extremely slow process of the infection in the disc as well as in the bone. On the other hand, infection by *Pseudomonas aeruginosa* in other body systems is characteristically acute. This raises the doubt about the patient's claims of abstinence; however, the presence of persistently high sedimentation rate and high gamma globulin, as well as the radiologic features, indicate the chronicity of the process. The low WBC counts, similar to those found in the literature, were not surprising.

It is estimated that the total number of addicts in the U.S.A. ranged between 75,000 to 200,000 until a few years ago.<sup>6</sup> Within the past few years, the pattern has been sharply altered, and the number of addicts has more than doubled. Lactose, maltose, quinine, quinidine, magnesium sulfate, baking soda and talc are used to dilute heroin 20 to 100 fold. The unsterile conditions of filling, packing and injecting the materials are apparently responsible for contamination and transmission of *Pseudomonas* as well as other microorganisms. Hematogenous transmission is believed to be the only way that *Pseudomonas* reach poorly vascularized regions such as the cartilaginous plates as well as the part of the vertebral body adjacent to the disc, and subsequently invade the disc. ◀

#### Acknowledgement:

We are thankful to Dr. Oscar Sugar for his Comments and Corrections.

#### References

1. Archer G., Fekety R. F., Supena R.: "Pseudomonas Aeruginosa Endocarditis in Drug Addicts," *American Heart Journal*, 88:570-578, November, 1974.
2. Bryan V., Lawrence F., Torres H.: "Pseudomonas Aeruginosa a Cervical Diskitis with Chondro Osteomyelitis in an Intravenous Drug Abuser," *Sur. Neurol.*, 1:142-144, 1973.
3. Holzman R. S., Bishko F.: "Osteomyelitis in Heroin Addicts." *Ann. J. of Internal Medicine*, 75:693-696, 1971.

4. Kurtzman R. S.: "Complications of Narcotic Addiction," *Radiology*, 96:23-30, July, 1970.
5. Lewis R., Gorbach S., Altner P.: "Spinal Pseudomonas Chondro-Osteomyelitis in Heroin Users," *New Eng. J. Med.*, 286:1303-1306, 1972.
6. Pfizer Pharmaceuticals, Sponsors for The Institute for the Study of Drug Addiction, 1972. "The Non-Medical Use of Drugs," *Contemporary Clinical Issues*.
7. Salahuddin N. I., Madhavan T.: "Pseudomonas Osteomyelitis; Radiologic Features," *Radiology*, 109:41-47, October, 1973.
8. Selby R., Pillay K. V.: "Osteomyelitis and Disc Infection Secondary to Pseudomonas Aeruginosa in Heroin Addiction," case report, *J. Neurosurg.*, 37:463-466, 1972.
9. Wiesseman G. J., Wood V. E., Kroll L.: "Pseudomonas Vertebral Osteomyelitis in Heroin Addicts, Report of Five Cases," *J. Bone and Joint Surgery*, 55A:1416-1424, 1973.

## EKG

(Continued from page 101)

Answers: 1. C,D,E 2. E

The ECG shows paroxysmal atrial fibrillation with a grossly irregular ventricular response at a rate of approximately 140 beats per minute. Clear cut flutter waves are not well seen here. The totally disorganized atrial electrical results in an irregular ventricular response. After atrial fibrillation converts to sinus rhythm, there is a relatively long escape interval. This long period of sinus node recovery, the irregular sinus cycles (nonrespiratory sinus arrhythmia) and alternating P wave contours with equal PR intervals could all be the result of overdrive suppression of the sinus node by the rapid atrial fibrillation. All may well represent a degree of sinus node depression. Atrial fibrillation is a common cardiac arrhythmia seen in any of the disease states listed above. Since atrial systole is lost, hemodynamic function deteriorates. The improvement in cardiac output upon conversion to sinus rhythm can vary from 0 to 43%. The degree of improvement in cardiac output is directly related to ventricular function. If the ventricles are normal no change might be noted while abnormal ventricles might require atrial systole and a regular rate for optimum function. In this patient digoxin maintained sinus rhythm in the presence of moderate rheumatic mitral stenosis.

# Cardiac Valve Replacement: Improved Survival Related to Air Exclusion and Myocardial Protection.

BY S. C. BALDERMAN, M.D./CHICAGO, R. J. BATES, M.D., M.Phil./CHICAGO, AND  
C. E. ANAGNOSTOPOULOS, M.D./CHICAGO

*This article presents operative mortality and long term results in 146 consecutive cases of cardiac valve replacements. The results in elective versus emergency procedures are constructed and the merits of selective myocardial protection and exclusion of air emboli in improving survival are discussed. A protocol for minimizing coronary and systematic air emboli is included.*

The operative mortality for procedures on the cardiac valves has steadily improved over the past ten years.<sup>1</sup> Many groups have recently reported 5-10% operative to one-month mortality rates for single valve replacement.<sup>2-5</sup> Several larger centers, such as the Texas Heart Institute, Mayo Clinic and University of Oregon, have reported operative mortalities of 0%, 8.9% and 2% respectively for selected series of single valve operations.<sup>6-8</sup> Excellent results, albeit with higher mortality, have also been reported in double and triple valve

replacement.<sup>9-11</sup> These improved results are the direct result of our increased understanding of cardiovascular physiology, advances in surgical techniques and improvement in prosthetic valve design and manufacture.

A uniform protocol for exclusion of air from the systemic and coronary circulation is now employed in all open procedures on the left side of the heart at the University of Chicago (Table I). The methods of myocardial protection from ischemic damage depend upon the nature of the specific case (Table II). In general, coronary artery perfusion has been reserved for the most complicated and prolonged procedures. In our last 122 consecutive "elective or urgent" operations for single and multiple valve disease, we have noted a decrease in the one-month operative mortality to 4%. In the same period, the operative mortality in 24 patients who underwent "emergency" valve replacements was 37%. We feel that these enhanced mortality rates are the result of improvements in myocardial protection and the prevention of systemic and coronary air embolism.

---

**ROBERT J. BATES, M.D., M.Phil.,** is a 1976 graduate of the University of Chicago Medical School. A specialist in surgery, Dr. Bates is a resident at Massachusetts General Hospital and, at this writing, was affiliated with the University of Chicago Hospitals and Clinics.

**SAMUEL C. BALDERMAN, M.D.,** is a fellow in cardiovascular surgery with Loyola University. He completed his senior residency at Michael Reese Hospital in 1976, and cites his major research interest as cardiovascular surgery.

**CONSTANTINE E. ANAGNOSTOPOULOS, M.D.,** is an established investigator for the American Heart Association. Dr. Anagnostopoulos is widely published in the area of cardiac research and is affiliated with the University of Chicago Hospitals.

Research for this article was conducted in cooperation with the Combined Cardiac Service, Section of Thoracic and Cardiovascular Surgery at the University of Chicago.

## Clinical Material

The clinical course of the last 146 patients to have open cardiac valve operations in the author's service (CEA) at the University of Chicago Hospitals were reviewed. The ages of the patients ranged from 27 to 78 with the average

**TABLE I**  
**Techniques of Avoiding Air Embolism**

1. Insert "Cooley needle" or create small stab wound in the aorta and place purse string around it, attached to a snare.
2. Compress aortic root manually.
3. Stop pump momentarily.
4. Release aortic cross clamp slowly.
5. Restart pump, allowing blood to fill aortic root.
6. Close off stab wound of aorta by placing tension on suture by means of snare.
7. In the presence of sinus rhythm, induce ventricular fibrillation immediately.
8. Trendelenburg position.
9. Increase left ventricular sump.
10. Elevate LV apex.
11. Release SVC & IVC snares.
12. Invagination of LA appendage and compression.
13. Needle aspirate LA & LV
14. Hyperinflate lungs manually and rotate patient 45° from side to side to remove peripheral pulmonary venous air.
15. Clamp side arm of LV sump or vent.
16. Decrease LV sump.
17. Release ascending aortic stab snare and allow bleeding.
18. Clamp ascending aorta temporarily and defibrillate.
19. Remove LV vent and allow apex to eject blood.
20. Compress LA.
21. Bag and rotate again.
22. Suture LV-apex.
23. Open aortic stab and lower LV into pericardium.
24. Close aortic stab.
25. Reposition patient to supine from Trendelenburg.
26. If air is seen in coronary arteries clamp ascending aorta and allow 3-4 cardiac beats to "flush" coronary air.

being 53 years. Sixty-five percent of the patients were males. Indications for surgery were based on clinical and laboratory findings. The overwhelming majority of patients (91%) were either Class

III or IV according to the New York Heart Association classification and their conditions were either non-improved or progressing with conservative management.

Twenty-four of our patients were very unstable or in cardiogenic shock preoperatively and were operated on the day of consultation. This group comprised the "emergency" group (Table III). One hundred and twenty-two scheduled "elective or urgent" operations were performed (Table IV). Thirty-one were re-operations for malfunctioning valves referred to us from outside this hospital.

Ninety-nine elective operations involved a single valve (Table IV). Included in this group were fifty mitral valve replacements, twenty-two open mitral commissurotomies and four mitral replacements with simultaneous aorto-coronary bypass grafts. Twenty-two aortic valves were replaced or re-replaced and in this subgroup five simultaneous aneurysmectomies of the ascending aorta were performed. Eighteen elective procedures on two or more valves were performed in 17 patients: seven aortic and mitral replacements, two aortic replacements and mitral commissurotomies, six mitral and tricuspid replacements and three mitral replacements with aortic valve exploration. In five cases surgery on three valves was performed.

One hundred and fifty-two prosthetic valves were used. Of these 65% were Starr-Edwards series 2320 aortic and series 6320 mitral or tricuspid prostheses. The remaining were approximately equally divided between Bjork-Shiley and Hancock porcine heterograft valves. These last two models have been used exclusively in the last 50 operations.

The valve most frequently replaced was the mitral (83 cases or 55%). This was followed by

**TABLE II**  
**Methods of Myocardial Protection**

<u>Operation</u>	<u>Technique Employed</u>
Mitral Commissurotomy, Tricuspid Operations	Intermittent Aortic Cross Clamp
Mitral Valve Replacement with Competent Aortic Valve	Fibrillation or Normal Sinus Rhythm, Brief Aortic Cross Clamp
Mitral Valve Replacement with Incompetent Aortic Valve	Aortic Cross Clamp with Iced Saline in Pericardial Well. If Redo and Prolonged, Coronary Artery Perfusion
Aortic Valve Replacement for Simple AI	Anoxic Arrest and Iced Saline
Aortic Valve Replacement—Complicated Case or Multiple Valve Replacement	Coronary Perfusion Alternating with Pericardial Iced Saline During Anoxic Periods

the aortic (51 cases or 34%) and the tricuspid (18 cases or 12%). Of the 152 prostheses used, ninety-two (61%) were used in single valve replacements and sixty (39%) were used in double or triple valve replacement operations.

### Operative Technique

The heart was approached through a median sternotomy in all cases. Cardiopulmonary bypass was conducted using hemodilution prime in an Olson pump, disposable bubble or membrane oxygenators, and mild hypothermia (30°C). Differing methods of myocardial protection were employed depending on the nature of the case (Table II). Venae cavae drainage was via the right atrium and perfusion was performed through the ascending aorta when possible in elective cases and through the femoral artery in emergency cases. The left ventricular vent was introduced into the apex of the ventricle in most patients. The left atrium and mitral valve were exposed through an incision posterior to the inter-atrial groove while the aortic valve was exposed by means of a "hockey-stick" incision on the ascending aorta.

Before discontinuing bypass, a combination of several previously described techniques were employed to avoid air emboli to the coronary and systemic circulations (Table I). This procedure was rigidly adhered to in all cases.

Following operation, all patients were observed in the intensive care unit for three to four days where most remained intubated for 12-24 hours. Patients with Bjork-Shiley prostheses or Starr mitral prostheses received anticoagulants indefinitely while those with Hancock heterografts were anticoagulated for six weeks only. Anti-

biotics were given prophylactically for the first five days in both groups.

### Results

There were five operative deaths (death within the first month) among the 122 elective or urgent valve procedures. Three of these deaths occurred following isolated mitral valve replacement (Table IV). Fifty-seven of the patients in this series of 146 cases underwent an operation other than a primary single valve replacement, i.e., re-replacement, double or triple valve replacement, or simultaneous coronary bypass or aneurysmectomies.

The 37 elective operations involving the aortic valve and 25 open mitral commissurotomies were performed without operative mortality. With an average followup of 2.5 years, there have been only six late deaths in the patients with elective operations (5%) and two late deaths in the emergency operation groups (8%). A survival of 63% was achieved for patients in the emergency group preoperatively (Table III). Air embolism was not a complication in this series of 146 cases.

These results suggest that a relatively small but well run cardiac surgical service can achieve results equal to or better than larger cardiac surgical centers despite the fact that a major portion of the patients present with complex valvular heart disease.

### Discussion

It has been well documented that air embolism to the coronary arteries is harmful to the myocardium and that patients with a previously compromised myocardium<sup>12</sup> will tolerate this added

TABLE III  
Results of 24 Emergency Valve Replacements\*

	No. of Patients	Survivors**
Mitral replacement	1	1
Mitral replacement, inferior vena cava ligation removal of pulmonary emboli	1	1
Mitral debridement (Bjork-Shiley)	1	1
Aortic Replacement or re-replacement	8	6
Tricuspid replacement	3	1
Aortic replacement and coronary operation	2	2
Mitral and tricuspid replacement	4	1
Aortic and mitral replacement	3	1
Aortic and tricuspid replacement	1	1
Total	24	15 (63%)

\*In very unstable condition or cardiogenic shock preoperatively.

\*\*Patients alive at one month post-operatively.



**TABLE IV**  
**Results of 122 Scheduled (Elective or Urgent) Valve Operations**  
**Using Extra-Corporeal Circulation**

Single Valve Operations (Including Reoperations and Causing Additional Cardiac Procedures)			
	No. of Patients	Survivors*	Late Deaths
Open mitral commissurotomy or re-commissurotomy	22	22	
Mitral replacement or re-replacement	50	47	1
Mitral replacement & coronary artery bypass and/or aneurysmectomy	4	4	1
Aortic replacement or re-replacement	22	22	1
Aortic replacement & coronary artery bypass	1	1	
Total	99	96 (97%)	3
Double Valve Operations			
Aortic & mitral replacement	7	7	1
Aortic replacement & mitral commissurotomy	2	2	
Mitral & tricuspid replacement	6	5	1
Mitral replacement & aortic exploration	3	2	1
Total	18	16 (89%)	3
Triple Valve Operations			
Aortic & mitral replacement with tricuspid commissurotomy	1	1	
Aortic & tricuspid replacement with mitral commissurotomy	1	1	
Aortic, mitral & tricuspid replacement	3	3	
Total	5	5 (100%)	
Total All Operations	122	117 (96%)	6

\*Patients alive at one month post-operatively.

insult poorly. All surgeons now employ methods for avoiding this potentially lethal complication.

Our protocol for the removal of intracardiac air during cardiopulmonary bypass combines many well known techniques documented as minimizing the occurrence of air embolism.<sup>13-17</sup> These include venting of the ascending aorta with either a needle or stab wound, elective fibrillation of the heart to prevent ejection, flooding of the left side of the heart with blood, placing the patient in the Trendelenberg position, the routine use of a left ventricular sump and needle aspiration of the cardiac chambers. We feel that the advantages of each technique are additive and can, therefore, be used in conjunction with benefit. Since taking this approach, our operative results have improved significantly. Although operative results are dependent on many variables, we feel that measures to reduce or eliminate air emboli and

selection of an appropriate form of myocardial protection are important positive factors, especially in those patients with advanced myocardial disease and minimal reserve.

Despite all measures taken, there are still instances where air is seen in branches of coronary arteries. Occlusion of the ascending aorta for three or four beats to allow coronary "flushing" is recommended. Precautions should be taken, however, to avoid overdistention of the proximal aorta. Should this occur, the aortic cross-clamp can be partially released. ◀

#### References

A complete bibliography for "Cardiac Valve Replacement: Improved Survival Related to Air Exclusion and Myocardial Protection" may be obtained by writing the *Illinois Medical Journal*, 55 E Monroe, Suite 3510, Chicago 60603.

# UNUSUAL POPLITEAL MASS

JAMES HILL, M.D., JOSEPH A. CAPRINI, M.D. AND  
WILLIAM J. DAWSON, M.D./EVANSTON

*Cystic lesions in the popliteal region as seen by orthopedic surgeons are frequently Baker's cysts, or popliteal cysts as they are sometimes called. These synovial fluid filled cysts arise from the gastrocnemius-semimembranous bursa which communicates with the knee joint in 50-65% of cases.<sup>1,8</sup> Since Good's report in 1964, physicians have been increasingly aware of the diagnostic difficulties associated with popliteal cysts, including co-existing thrombophlebitis.<sup>2</sup>*

*This report of a popliteal hematoma mimicking both thrombophlebitis and ruptured dissecting Baker's cyst illustrates further diagnostic problems associated with popliteal masses.*

## Case Report

The patient is a 45-year-old female who complained of pain behind the right knee two days following gardening; pain was primarily in the right popliteal region and a right popliteal mass was noted on the morning of admission. She denied any previous symptoms or problems with this joint.

Initial physical examination revealed ecchymosis of the right popliteal fossa and proximal calf. Tenderness to palpation was noted over these areas, worse on the medial aspect. Diffuse firmness in the right popliteal fossa was noted, accentuated by knee extension. Right calf diameter was 2 cm. larger, Homan's sign was strongly positive, and distal pulses and neurologic examination were normal. Active plantar flexion duplicated her symptoms. X-rays revealed slight narrowing of the medial joint space with early tibial plateau sclerosis. Admission hematocrit, coagulation profile, and vital signs were within normal limits.

Twenty-four hours after bedrest, elevation, and local heat, ecchymosis had increased and a definite popliteal mass was noted. The presump-

---

JAMES A. HILL, M.D., is a resident in orthopedic surgery at the Northwestern University Medical Center.



WILLIAM JAMES DAWSON, M.D., is chief of the limb replantation section at Evanston Hospital department of surgery, as well as an attending staff member. Dr. Dawson is an associate in orthopaedic surgery at Northwestern University Medical School, and lists his specialization as orthopaedic and hand surgery.



---

JOSEPH A. CAPRINI, M.D., is a specialist in general surgery and coagulation disorders. He is affiliated with Evanston Hospital, where he serves as director of the coagulation research laboratory, attending physician in the surgical ward service, director of surgical research, associate attending staff and director of the blood flow laboratory. Dr. Caprini is also attending staff at the Veterans Lakeside Hospital in Chicago, and an assistant professor of pathology and surgery at Northwestern University Medical School.





**Figure 1**  
**Venography A-P Right leg. Demonstrates lateral displacement of the popliteal vein.**

tive diagnosis was Baker's cyst with possible thrombophlebitis, and 800 units sodium heparin was administered hourly. The next day, Doppler studies revealed turbulent flow in the right femoral vein, but the popliteal and calf flow were normal. Heparin was increased to 1,000 units per hour because of a PTT of 29 seconds.

The clinical picture remained unchanged for 48 hours and venography was done. No venous thrombosis was seen, although posterior and lateral displacement of the popliteal vein was observed (Fig. 1-2). Arteriography revealed lateral displacement of the popliteal artery with posterior bowing of popliteal and descending geniculate arteries (Fig. 3-4).

Aspiration of the mass revealed old blood without evidence of synovial fluid or gelatinous material. A striking finding was the radical increase of ecchymosis while the blood count and coagulation profile remained normal.

At operation, 24 hours later, the deep fascia overlying the gastrocnemius muscle was found to be the roof of a hematoma three inches in diameter, containing 150cc of clotted blood, without active bleeding. The hematoma was on the medial side of the posterior calf and was superficial to the medial head of the gastroc-



**Figure 2**  
**Venography lateral Right leg. Demonstrates posterior displacement of the popliteal vein.**

nemius. No additional histologic findings were found in the aspirated material. Five hundred units of heparin were given hourly for five days. Repeat Doppler studies were normal, and the patient recovered uneventfully.

### Discussion

Cystic lesions in the popliteal region may be of intra- or extra-articular origin. Extra-articular causes include popliteal aneurysm, varices, or soft tissue tumors. Intra-articular causes are pigmented villonodular synovitis, septic arthritis, or most commonly, a Baker's cyst, which is associated with rheumatoid arthritis, osteoarthritis, meniscus tears or any condition which leads to a chronic effusion.

Recently, many reports have emphasized the presentation of ruptured and unruptured dissecting Baker's cysts with symptoms suggesting

thrombophlebitis, *i.e.*, calf pain, calf tenderness, erythema, ankle edema, and positive Homan sign.<sup>2-7</sup>

This case illustrates several features which differentiate it from a rupture or dissection of a Baker's cyst, including the lack of a preceding

mass or chronic internal derangement of the knee and presence of ecchymosis in the popliteal fossa. This latter finding has never been reported in association with a ruptured Baker's cyst. Perhaps the ecchymosis was an expression of the hematoma, possibly caused by small vessel rupture from prolonged kneeling. Double contrast arthrography would have been helpful as a diagnostic tool since virtually all Baker's cysts fill with contrast material. In this case, ultrasound B-Scanning, advocated by McDonald and Sweet, also could have been helpful in discerning the lesion and avoiding anticoagulation with its inherent risks.<sup>3,7</sup> Finally, needle aspiration is a useful tool if rare lesions such as pigmented villonodular synovitis, which can cause one to obtain serosanguineous fluid, are entertained.

Although blood tests remained normal, the heparin employed in this case probably intensified the local bleeding problem. We feel it is imperative to establish the presence or absence of deep vein thrombosis, and in this case, early

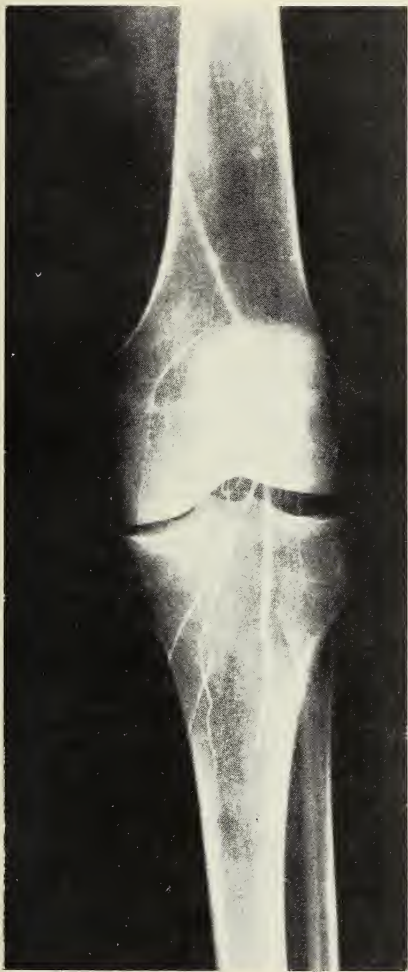


Figure 3  
Arteriography A-P Right leg. Demonstrates lateral displacement of the popliteal artery.



Figure 4  
Arteriography lateral Right leg. Demonstrates posterior displacement of the popliteal and descending geniculate arteries.



venography should have been done. It is interesting that normal popliteal Doppler flow was observed. Finally, the value of aspiration is demonstrated in this patient and is a most useful diagnostic aid, particularly if pigmented villonodular synovitis is present.

### Summary

The report describes a patient who presented with a mass in the medial aspect of her right popliteal fossa. The presentation of the mass was similar to a ruptured or unruptured dissecting Baker's cyst, but surgical exploration revealed a popliteal hematoma. The distinguishing characteristics of the case are elucidated and the various diagnostic modalities available are described. ◀

### References

1. Burlison, R. J., Bickel, W. H., and Dahlin, D. C.: "Popliteal Cyst," *JBJS* 38A:1274, 1956.
2. Good, A. E.: "Rheumatoid Arthritis, Baker's Cyst and Thrombophlebitis," *Arth. and Rheum.*, 7:56-64, 1974.
3. McDonald, D. G. and Leopold, G. R.: "Ultrasound B-Scanning in the Differentiation of Baker's Cyst and Thrombophlebitis," *Brit. Jour. of Rad.*, 45:729-732, 1972.
4. Perri, J. A., Rodnan, G. P., and Mankin, H. J.: "Giant Synovial Cysts of the Calf in Patients with Rheumatoid Arthritis," *JBJS* 50A:709-719, 1968.
5. Schmidt, M. C., Workman, J. B., and Barth, W. F.: "Dissection or Rupture of a Popliteal Cyst," *Arch. Intern. Med.* 134:694-698, 1974.
6. Solomon, L. and Berman, L.: "Synovial Rupture of the Knee Joint," *JBJS* 54B:460-467, 1972.
7. Sweet, H. A., Jaffe, R. B., and McIlff, E. B.: "Popliteal Cysts: Presentation as Thrombophlebitis," *Rad.* 115: 613-615, 1975.
8. Wolfe, R. D. and Colloff, B.: "Popliteal Cysts," *JBJS* 54A:1057-1063, 1972.

## LOW-COST GROUP INSURANCE ANOTHER ISMS MEMBERSHIP PRIVILEGE

FOR INFORMATION,  
ASSISTANCE  
& DETAILS CONTACT:

Administrators:

**PARKER, VESLURE & COMPANY**  
ESTABLISHED 1901  
*Insurance*

**THE GROUP DISABILITY PLAN** ● Provides up to \$1,732.00 monthly in the event of disability caused by Accident or Sickness. ● Special Guaranteed renewal feature. ● Protect your income and security.

**BUSINESS OVERHEAD EXPENSE PLAN** ● Pays your office overhead expense when disability strikes. ● Premiums are Tax Deductible. ● Pays in Addition to the Disability Plan Benefits.

**THE BASIC MAJOR MEDICAL EXPENSE PLAN** ● In or out of Hospital Benefits up to \$25,000.00 per Disability. ● Up to \$100.00 Daily Hospital Room and Board maximum. ● Subject to choice of deductible and 80% coinsurance.

**EXCESS MAJOR MEDICAL PLAN** ● Provides up to \$250,000 for Medical Expenses. ● Supplements any Basic Major Medical Plan and has a \$25,000 deductible. ● Low group rates. ● Truly catastrophic coverage.

**9933 N. Lawler Avenue**  
**Skokie, Illinois 60076**  
**Phone: 312-679-1000**

# A Decerebrate Patient: Eighteen Years of Care

ROBERT E. FIELD, M.D. AND RAYMOND J. ROMANUS, M.D./BLUE ISLAND AND HARVEY

*This is a summary of the care given for eighteen years to a patient, who was decerebrate at mid-level, with quadriplegia, anesthesia and analgesia. During the entire period from her injury October 28, 1956 until death March 31, 1974, treatment was in a general community hospital.*

## History

On October 28, 1956, an expert horsewoman, age 27, was riding her mount in an outdoor arena which was surrounded by a high wooden paddock fence with large upright posts. One of us (RF) was riding within a few hundred feet of the arena. In response to the cry of spectators, RF observed the horse standing riderless in the arena and the young woman lying on her left side, with her head next to an upright post. Within perhaps 20-30 seconds RF dismounted and was at the patient's side. She was deeply unconscious, not breathing, both pupils were dilated, and the peripheral pulse was absent.

The patient was rolled on her back and artificial respiratory maneuvers of her chest were begun. Shortly, her pulse became weakly per-

ceptible and spontaneous respiratory activity gradually returned. During this time the ambulance arrived and oxygen was administered. There is no record of the exact time element which elapsed during these various phases of care. At no time during transit to the hospital did the patient regain consciousness. Her respirations were very slow and labored and the pulse was extremely weak. Transfer was directly from the riding area to St. Francis Hospital, Blue Island, a distance of approximately ten miles.

## Hospital Course

**1956—Age 27:** The patient was admitted to the hospital where resuscitation was continued. After IV feedings for several days, naso-gastric tube feedings were begun. There were times when very soft foods in small amounts were introduced and occasionally swallowed. The patient required frequent oral suction. The urine output was adequate, but she developed several episodes of urinary tract infection. There were occasional periods where the body would become rigid and spastic with occasional jerking. The Foley® catheter was changed about every three weeks, the naso-gastric tube about 10 to 14 days. Her position was changed every three to four hours with extensive skin care and range of motion exercises to the extremities three to four times a day. Antibiotics, aspirin and occasional Fleet® enemas were given. During this period she was seen by six neurologists and neurosurgeons.

**1957—Age 28:** The patient was transferred to

---

**ROBERT E. FIELD, M.D.,** is a specialist in general and thoracic surgery affiliated with St. Francis Hospital in Blue Island and Ingalls Memorial Hospital in Harvey. At Ingalls Memorial Hospital he has served as chairman of the department of surgery, president of the medical staff, and also chairman of the Cancer Committee and Tumor Board. At St. Francis Hospital he has served as chairman of the department of surgery and president of the medical staff.

**RAYMOND J. ROMANUS, M.D.,** is a specialist in general and thoracic surgery and a member of the surgical staffs of both St. Francis and Ingalls Memorial Hospital. Dr. Romanus is a fellow of the American College of Surgeons and also the International College of Surgeons.

the University of Illinois Research Hospital for thirty days. The evaluation resulted in a diagnosis of "suspect contusion cerebral cortex and basal ganglia; encephalomalacia of the internal capsule and/or midbrain due to hemorrhage, not improved." She was returned to the hospital, where she was again maintained on nasogastric feedings of approximately 2,000 calories a day. Occasionally, very soft oral feedings in small amounts were taken. During this time, she experienced some weight increase which was controlled by decreasing her caloric intake. She experienced several episodes of aspiration pneumonia and urinary tract infections. She was also begun on Dilantin® at this time for her convulsive disorders and spastic movements.

*1958—Age 29:* She was transferred for twelve days to Wesley Memorial Hospital for evaluation. Work-up was essentially the same with no change in the diagnosis. She had several severe convulsions with cyanosis during this year and the patient was noted to have regular menstrual periods.

*1959—Age 30:* The patient's weight was stable. She was having more frequent convulsive episodes. There was an abrasion on the buttocks which healed satisfactorily with routine care. There was also some redness of the coccygeal area for about four days which healed satisfactorily.

*1960—Age 31:* The patient was noted to have more difficulties with aspiration pneumonitis. The convulsions were persisting, with cyanosis at times. The Foley® catheter would have to be re-inserted more frequently and usually larger sizes were necessary.

*1961—Age 32:* The liquid intake was again 4800cc. This year, several units of whole blood were given for an anemia. She also underwent a thoracentesis at which time 200cc of fluid was obtained. There was a paracentesis of small amount of fluid. The patient was known to have an ileus during this period. The X-rays revealed a pleural effusion with question of a hemothorax and there was no growth on the culture of the aspirant fluid. There was some cloudy density of both lungs.

*1962—Age 33:* The patient's weight was regular. She had a small amount of purulent drainage from her toe, which responded to conservative treatment. The menses became somewhat irregular.

*1963-67 Ages 34-38:* During these years, the weight was fairly stable. The patient was maintained on Dilantin®. During this time, she was

begun on IPPB whenever she would experience evidence of pneumonia. She would develop periocular edema which was treated with ointments. In 1964 she underwent a cystoscopic examination for a neurogenic bladder. She developed several episodes of dermatitis. Also her periods would occasionally be irregular with clots.

*1968-69 Ages 39-40:* She was still being occasionally fed small amounts of baby food which she would tolerate very poorly. Several episodes of febrile convulsions were noted during this period. The patient was noted to have an excoriated coccygeal area which was treated conservatively and after several months appeared to be healing satisfactorily.

*1970—Age 41:* No further attempts were made at oral feedings. The nutrition was adequately maintained by nasogastric feeding. The patient usually appeared to be very congested, requiring extensive and frequent oral suctioning. She had increasing convulsions at this time.

*1971—Age 42:* This year the patient appeared to require constant care throughout the year with many episodes of febrile convulsions and cyanosis. She developed a vaginal infection and the perineal area became excoriated and treated with topical medications.

*1972—Age 43:* The patient's weight appeared to be increasing and the diet was gradually decreased. She was getting IPPB with Mucomist three to four times a day throughout the year. Vaporizer was maintained in her room. A small area of excoriation of the ear lobe was treated and the perineal and buttock rash cleared using various ointments. The patient began experiencing episodes of tremors and convulsions more frequently and required almost constant oral suctioning.

*1973—Age 44:* Occasionally she was given some diuretics during this time. The tremors persisted and increased in severity. Continual care with close observation was necessary. The menses became very scant and irregular during this year.

*1974—Age 45:* The patient at this time appeared to be retaining more of her body fluids. Her weight had increased. She was maintained on IPPB throughout this period. Genitourinary infection and tremors were increasing in severity. On March 21, abdominal breathing was noted and the respirations became extremely labored. The patient was maintained on oxygen, respiratory therapy, and antibiotics. On March 23, the urine output diminished. Her condition began to deteriorate rapidly and on March 31, the patient expired.

## Autopsy

### Final Anatomical Diagnoses

1. Focal acute and resolving bronchopneumonia.
  - Edema and focal hemorrhages.
  - Very extensive pulmonary fibrosis.
  - Foci of lipid pneumonia (endogenous).
  - Focal lipid granulomas.
  - Bone marrow emboli in small pulmonary artery.
  - Fibrosed granuloma.
  - Fibrous pleurisy.
2. Atrophy of the brain (850 grams).
  - Extreme atrophy of fronto-parietal cortices, most marked in the right hemisphere (cortex less than 0.1 cm. thick.)
  - Associated dilation of both lateral ventricles, most marked on the right side.
  - Fibrosis of overlying meninges.
  - All sections of the brain show microscopic loss of neurons with increased numbers of glial cells.
  - Areas consistent with old infarcts are noted in the right frontal cortex, left occipital cortex, and left basal ganglia.
  - Bilateral atrophy of hippocampal gyri.
  - Degenerative changes in cerebellum.
3. Focal chronic pyelonephritis, bilateral.
4. Atrophy of skeletal muscle with fatty infiltration.
5. Chronic cystitis with squamous metaplasia of the bladder epithelium.
6. Small uterine leiomyoma.
  - Follicle cysts in ovaries.

### Discussion

This case is presented from many interesting factors. The length of survival was indeed long, from October 28, 1956, to March 31, 1974. The patient was maintained mostly by naso-gastric tube feedings throughout this period. By changing the calories and amount of feedings her weight was satisfactorily controlled. The problems of aspiration and pneumonia, along with urinary tract infections were not unexpected. These were treated and usually responded satisfactorily. The difficulties with Foley® catheters resulted in frequent changes every two to three weeks with larger sizes being used throughout. The convulsions, which appeared to be controlled

for some time with Dilantin®, gradually increased in severity and later Valium®, both intravenously and intramuscularly, was required. Other difficulties were occasional conjunctivitis and dermatitis. Pap smears were done during her hospital stay and were negative. Of course, the most remarkable features were the lack of large decubital ulcers on the skin.

This case does show that excellent care was given in a general community hospital to a decerebrate, quadraplegic patient. During her hospital course, there were two transfers to teaching centers for evaluation. She was also seen by nine neurologists and neurosurgeons. The remainder of her care was by two ophthalmologists, a general practitioner, three internists, urologists, OB-Gynecologists and also a dermatologist. Her primary care was under the physician (RF) who initially resuscitated her. This case could also be considered a tribute to the nurses, the LPN's, aides, dietitians and her parents who participated in her care.

### Summary

In reviewing this case, one comes to the question of the economics involved and perhaps the moral issues of maintaining life where there is no hope for mental survival of the patient.

This patient survived as a living body only because of intensive, continuing and highly personalized medical care afforded by the hospital staff and acutely concerned parents. We are convinced her survival for this period of time would not have been possible under other circumstances, i.e., domiciliary care or a convalescent home. The cost of such care is astronomical. One can project the cost of 18 years of hospitalization under private or semi-private accommodations on today's cost basis, and a rather unbelievable figure is obtained. One would need to add to this the cost of specialized and personalized care, and in addition, attending physicians' fees.

The morality involves the continuing care of an individual who has no possible recovery from a situation in which there is no function of the higher brain centers. From time to time, the patient's parents would make statements that "She is better today" and infer that indeed some conscious response was being made. However, at no time did the "uninvolved" observer detect such response. We can only conjecture as to the right moral stance to be taken in the care of this type of patient.

The compassionate attitude toward the patient's parents and the acceptance of the standard of "Where there is life, there's hope" were the ruling motives in caring for this individual. ◀



# IMPAC

## ILLINOIS MEDICAL POLITICAL ACTION COMMITTEE

55 East Monroe Street  
Chicago, Illinois 60603  
312/782-1963

*The person who says  
that he is above politics  
is really saying that  
democracy is beneath him.*

This Certainly Isn't You . . . Is It? Join IMPAC Today

### IMPAC/AMPAC Membership

(check one)

- ☐ Sustaining . . . . . \$99  
☐ Family . . . . . \$45  
☐ Regular . . . . . \$25  
☐ Auxiliary . . . . . \$20

Return to:

IMPAC  
55 E. Monroe Street  
Suite 3510  
Chicago, Illinois 60630

NAME \_\_\_\_\_ PHONE \_\_\_\_\_

ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ ZIP \_\_\_\_\_

A copy of our report filed with the State Board of Elections is (or will be) available for purchase from the State Board of Elections, 1020 S. Spring  
Springfield, Illinois, 62704. Federal reports are filed with the Federal Election Commission 1325 "K" Street, N.W., Washington, D.C. 20463.

# PELVIC LIPOMATOSIS

BY JOSEPH F. NORFRAY, M.D., LAWRENCE SCHLACHTER, M.D., AND  
WILLIAM J. HEISER, M.D./CHICAGO

*Pelvic lipomatosis is a benign proliferation of adipose tissue in the abdominal pelvis. Urinary tract obstruction and confusion with more ominous diseases—i.e., lymphogranuloma venereum, the frozen pelvis in malignancy, blood in the pelvis from trauma, or inferior vena cava obstruction—gives importance to a little known disease. It is probably more common than the literature would indicate.*

In 1959, Engels<sup>1</sup> noted that large amounts of fatty tissue could simulate pelvic tumors. Fogg and Smyth<sup>2</sup> presented five cases in 1968, and used the term pelvic lipomatosis to describe the "overgrowth of normal fatty tissue, limited to the

perirectal and the perivesical spaces in the pelvis." By 1974, approximately 40 cases had been reported.<sup>3</sup> The clinical and radiographic findings have been well-documented in the radiological and the urological literature. Because of its limited presentation in other literatures, it seems warranted to review a recent case at our hospital.

## Case Report

R.N., a 74-year-old Negro man, entered the hospital complaining of crampy epigastric pain for twelve hours duration accompanied by nausea, vomiting and diarrhea. He denied any urinary symptoms. On physical examination he was afebrile, and his weight was normal for his height (i.e., 190 pounds/6 feet 2 inches). The abdominal examination was unremarkable except for epigastric tenderness with increased bowel sounds. No masses were felt.

His admission WBC was 12,700 with a shift to the left. By the second hospital day the patient became febrile, with the temperature rising to 102°<sup>4</sup> on the third hospital day. Roentgenographic studies showed nonvisualization of the gallbladder on the original and repeat oral cholecystograms. The barium enema and intravenous pyelogram showed the classical findings of pelvic lipomatosis. (Figs. 1,2,3,4) The diagnosis of acute cholecystitis was made and cholecystectomy was advised. However, by the sixth hospital day the patient became asymptomatic and

**JOSEPH F. NORFRAY, M.D.**, is a radiologist and senior attending staff at Henrotin Hospital in Chicago. Dr. Norfray is a member of the Radiologist Society of North American and the American College of Radiology.



**LAWRENCE SCHLACHTER, M.D.**, is chief of the radiology section at Henrotin Hospital and an associate in radiology at Northwestern University Medical School. Dr. Schlachter specializes in radiology and nuclear medicine.



**WILLIAM J. HEISER, M.D.**, is senior attending staff at Henrotin Hospital and secretary-treasurer of the medical staff at the hospital. Dr. Heiser is also an instructor at Northwestern University.





**Figure 1**  
Intravenous pyelogram showing mild dilatation of the upper urinary tracts.



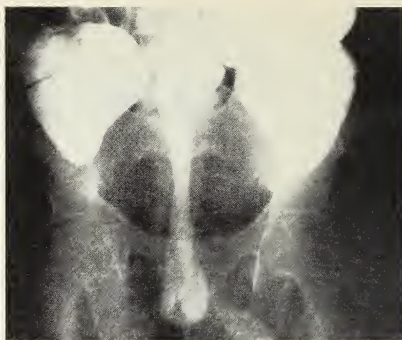
**Figure 2**  
Bladder film during intravenous pyelogram showing vertical elongation of the bladder.

refused cholecystectomy. The patient is being followed as an outpatient.

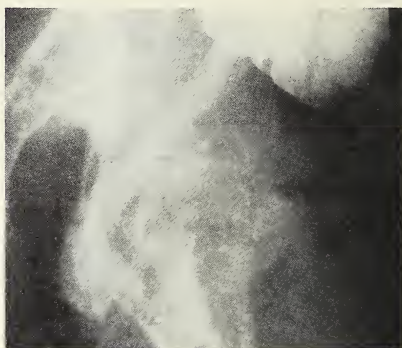
### Discussion

#### Pathology

Pelvic lipomatosis is a nonmalignant over-



**Figure 3**  
Barium enema demonstrating the tubular narrowing of the rectum and distal sigmoid. The descending colon, cecum, and terminal ileum are displaced out of the pelvis.



**Figure 4**  
Lateral view of the rectum on the barium enema showing the tubular narrowing of the rectum, plus the increase in the presacral space.

growth of fatty tissue. Numerous surgical explorations have found nonencapsulated fatty tissue which is adherent to the vital structures in the pelvis.<sup>4</sup> Histological findings have found normal nuclear and cytoplasmic morphology.<sup>2</sup> To explain the overgrowth of normal fatty tissue, various theories have been proposed including hormonal imbalance<sup>5</sup> and genitourinary infections.<sup>1</sup> None of the theories have been substantiated.

#### Sex/Age

Only four cases of pelvic lipomatosis have been

described in women.<sup>6-8</sup> There is at least a 10:1 ratio of men to women with the patient ages ranging from 25 to 80. Several authors have noted that upper urinary tract obstruction occurs more frequently in the younger patient.<sup>9-13</sup>

### *Symptoms*

The patients usually present with genitourinary symptoms—frequency,<sup>1,2</sup> dysuria,<sup>11,14</sup> difficulty starting urination,<sup>4,5,14</sup> perineal pain,<sup>15</sup> or flank pain from pyelonephritis.<sup>12</sup> Gastrointestinal symptoms occur less frequently and present as mild constipation.<sup>2</sup> Pelvic lipomatosis has never caused bowel obstruction.<sup>5</sup> There is one reported case of pelvic lipomatosis presenting as thrombophlebitis from inferior vena cava obstruction.<sup>3</sup>

### *Physical Examination*

Obesity doesn't seem to be a major contributing factor for the patient may be of normal weight,<sup>2,14</sup> or the patient may be obese.<sup>5-8,15</sup> The abdominal examination usually elicits a vague suprapubic mass which in some patients represents the distended, elevated bladder.<sup>2,4</sup> On the rectal examination the prostate is high in position due to elevation from the fatty tissue.<sup>4</sup> In most cases a pelvic mass representing the fatty tissue can be palpated on the rectal exam.<sup>16</sup>

The cystoscopic examination is usually difficult or impossible because of the elongation of the prostatic urethra due to the encompassing fatty tissue.<sup>4,14</sup> Eight of the patients have been found to have cystitis cystica, bullous edema, or cystitis glandularis.<sup>1,2,10-12,17</sup>

### *Roentgenographic Examination*

Roentgenographic studies are diagnostic for pelvic lipomatosis. The plain film of the abdomen reveals a radiolucent pelvis, and is due to the lower radiographic density of fat.<sup>5,16</sup> The intravenous pyelogram usually shows a normal upper collecting system. Infrequently, a mild to severe dilatation of the calyces, pelvis, and the ureters develops.<sup>2,10-12,15</sup> The bladder has a characteristic shape being described as "tear-shaped."<sup>5</sup> The vertical elongation of the bladder, the elevation of the base of the bladder, and the anterior displacement is due to the encompassing fatty tissue.<sup>1,4,5,9,15</sup> The post-voiding film shows a normal mucosal pattern with normal contraction.

On the barium enema the overgrowth of fatty tissue causes a vertical, tubular narrowing of the rectum and distal sigmoid colon. The other bowel loops are displaced out of the pelvis. There is an increase in the presacral space and decreased distensibility of the rectum. There is

normal mucosal pattern on the evacuation film.<sup>5,16</sup>

Since the roentgenographic studies are classical, diagnostic laparotomy is not justified.<sup>4,16</sup>

### *Treatment*

Because the etiology of pelvic lipomatosis is unknown, treatment is directed to the problems which arise, i.e., infection and obstruction. Lucey<sup>11</sup> and Emanuel<sup>17</sup> have suggested the use of long term antibiotic therapy to prevent mucosal changes seen in chronic infections. Obstruction of the collecting system has been treated by: transurethral resection of the proliferating mucosa,<sup>11,17</sup> ileal conduit,<sup>2,12</sup> nephrostomies,<sup>12</sup> nephroureterectomy,<sup>11</sup> reimplantation of the ureter into the bladder,<sup>11</sup> and extensive removal of the fatty tissue around the ureters and bladder.<sup>10.</sup>

### *Prognosis*

Pelvic lipomatosis can have either a quiescent or ominous course. Goldstein<sup>7</sup> and Becker<sup>4</sup> have followed patients for eight and nine years respectively with little radiographic change in the pelvic fatty tissue. Lucey<sup>11</sup> has suggested that urinary obstruction occurs in the younger patient. In the individual case, the prognosis is based on the degree of urinary obstruction, and the success of surgical intervention to prevent uremia.

### *Differential Diagnosis*

The patient's history and roentgenographic studies allow the clinician to exclude other entities. The normal mucosal pattern on the barium enema in pelvic lipomatosis excludes lymphogranuloma venereum and a frozen pelvis from malignancy. The lack of trauma eliminates the consideration of blood in the pelvis. A radiolucent pelvis, or a normal inferior vena caval venogram rules out dilated veins compressing the pelvic structures.

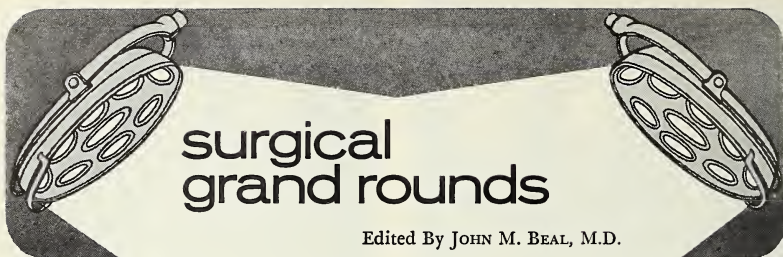
### **Conclusion**

Pelvic lipomatosis is a nonmalignant overgrowth of adipose tissue in the abdominal pelvis. The clinical history and the classical roentgenographic findings makes diagnostic laparotomy unnecessary. Urinary tract infection and obstruction are infrequent complications. Treatment and prognosis are directed towards the complications. ◀

### **References**

A complete list of references for "Pelvic Lipomatosis" may be obtained by writing the Illinois Medical Journal, 55 E. Monroe, Suite 3510, Chicago, Illinois 60603.





*Surgical Grand Rounds are held weekly on Tuesday at 5:00 p.m. in the Offield Auditorium of the Passavant Pavilion of Northwestern Memorial Hospital. Patient presentations from Northwestern Memorial Hospital and the Veterans Administration Lakeside Hospital form the basis of the discussions. This case report was part of the Surgical Grand Rounds of August 17, 1976.*

## Case Report: Adrenal Tumor

**Dr. Robert Gordon:** A 68-year-old woman was admitted to the Northwestern Memorial Hospital with the chief complaint of frontal balding of six month's duration. She also complained of an increased amount of hair on her face, on her abdomen, and on her chest. Her only other complaint was increased appetite with a weight gain of 14 lbs. Her past history and review of systems were noncontributory.

Physical examination revealed a well nourished and developed woman of the stated age with frontal balding and increased hair on the back, shoulders and pubis. Clitoral enlargement was present.

Routine laboratory studies were within normal limits. Chest X-ray detected a nodule on the right middle lung field, which was considered to be benign by tomography. Skull films were normal.

Ultrasound examination was performed and a left suprarenal mass with internal echoes was reported. A venogram was also obtained. Excre-

tion of adrenal cortical products was tested. Laboratory tests showed that urinary 17-ketosteroids were 82.2, 70.7 and 89.8 mg on consecutive days (normal for women: 5-16 mg/24 hrs.) and 17-hydroxysteroid excretion ranged from 6.8 to 10.4 mg/24 hrs. (normal range: 4-10 mg/24 hrs.). Dexamethasone was administered but did not suppress her excretion of 17-ketosteroid nor did it influence the excretion of 17-hydroxysteroids. Her testosterone level was 280 mg%.

**Dr. William Silverstein:** The left adrenal gland was visualized by venography, using Renografin® 60%. Enlarged veins are demonstrated both centrally and peripherally and are displaced by a mass (Figure 1). There is some irregularity of the vessels, which raises the possibility of the presence of carcinoma. At the time of the venogram, this question was not resolved.

**Dr. Robert Gordon:** The patient was taken to the operating room on August 2, 1976 and the left adrenal was exposed through a left flank incision. An adrenal tumor, approximately 5.5 cm

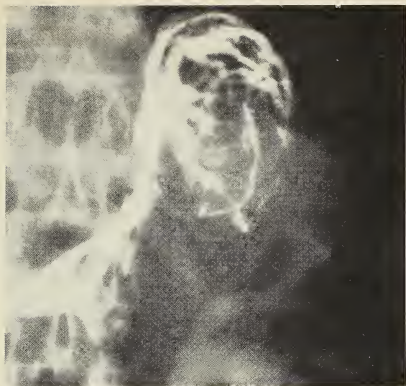


Figure 1

Venogram of left adrenal demonstrated mass with abnormal vascularity.

in diameter was found. The tumor along with attached normal adrenal was excised. The patient tolerated the procedure well and was discharged nine days postoperatively without complications. Before discharge, two 24-hour urinary collections for 17-ketosteroids were obtained. The first collection showed a value of 17.2 mg.; the repeat was 9.5 mg/24 hours.

**Dr. Hector Battifora:** The specimen was about 4.5 cm in diameter. A small portion of normal or perhaps somewhat atrophic adrenal and part of the tumor was covered by an extremely stretched adrenal cortex. The gross pictures are consistent with a benign tumor, an adenoma of the adrenal (Figure 2). There is no evidence of invasion or permeation of the adrenal capsule and the fat could be easily re-

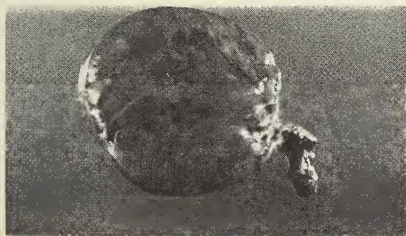


Figure 2

The specimen has been bisected and appears to be well encapsulated.

moved from the adrenal. All these features are very important in establishing the benignity of this tumor.

The tumor had a rather significant amount of pleomorphism. In some areas, there were very bizarre cells (Figure 3), yet despite these findings, this tumor is most likely benign. Such inordinate degrees of cell atypia are not unusual in adenomas of the cortex.

With the electron microscope, this tumor has features one would expect to see in adrenal cortex. Normally, mitochondria in most organs have shell-like cristae; in the adrenal cortex, they are tubular. In addition to that, there is a lot of agranular endoplasmic reticulum. These

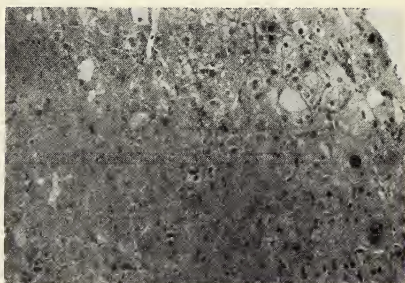


Figure 3

Microscopic examination showed areas of marked pleomorphism.

peculiar mitochondria and endoplasmic reticulum are characteristic of cells synthesizing cholesterol in preparation for the production of hormones.

**Dr. Sheldon Waldstein:** This is not a common lesion. I will discuss the endocrinologic considerations in the evaluation of a woman with signs of virilization. **When virilism is encountered in a postmenopausal woman or even in a menstruating woman beyond the age of 30, sudden development of virilization is usually caused by a tumor, either adrenal or ovarian.**

One has to first be certain that one is dealing with virilization rather than hirsutism. The patient today had pronounced receding hairline and in addition clitoral hypertrophy, evidences of virilism. The initial urinary 17-ketosteroid excretion was determined by her referring physician and had been in the range of 30mg/day. Ketosteroids are largely a reflection of androgen

metabolism and in women are primarily of adrenal origin.

**In general, high urinary levels of 17-ketosteroids and relatively low testosterone values suggest an adrenal lesion. In contrast, high testosterone levels and relatively modest elevation of the ketosteroids are compatible with an ovarian lesion.** In the patient who has been discussed today, the 17-ketosteroid level was so high that an ovarian lesion was highly unlikely. These concepts are important because virilizing ovarian lesions may not be detected by pelvic examination.

In a younger person, however, the possibility of bilateral adrenal hyperplasia must be considered. Congenital bilateral adrenal hyperplasia is thought to be the result of a compensatory mechanism, caused by a defect in the formation of cortisol. This causes insufficient feedback regulation of ACTH. The excessive production of ACTH leads to adrenal hyperplasia. A side effect of excessive ACTH production is increased androgen excretion. Androgens do not participate in the feedback mechanism to turn off ACTH. Congenital adrenal hyperplasia, most commonly seen in the newborn or in very early childhood, may cause precocious puberty and virilization and is treated medically.

It should be mentioned that adrenal carcinoma can result in virilization. Several years ago, we treated a woman at another hospital who had a huge abdominal tumor mass and who had extreme virilization. The mass proved to be a large adrenal carcinoma.

**Dr. Robert Gordon:** The surgical history of adrenal tumors begins with Thornton (1899) who removed the first adrenocortical tumor. Cushing (1932) defined the relationship of the pituitary and the adrenal glands. Young (1937) described the surgical approach to the adrenal gland. Tumors of the adrenal cortex, with which we are concerned today, may present in any one of a number of ways. Primarily, tumors of the adrenal cortex are detected because of the presence of an abdominal mass. Cushing's syndrome results from an excessive production of cortisol. Conn's syndrome is caused by excessive production of aldosterone.

Before operation was performed, the possibility that this patient might have carcinoma of the adrenal cortex was considered. She had several characteristics which are frequently found in adrenal carcinoma: lack of response to ACTH stimulation, markedly elevated 17-ketosteroids, a relatively rapid onset of manifestations, virilizing

changes and a tumor that appeared to be greater than 5 cm in diameter.

Although the primary treatment of carcinoma of the adrenal gland is surgery, metastases are usually present. The survival rate for carcinoma of the adrenal gland for one year is approximately 8% and five year survival is approximately 9%. However, at the time of operation, the gross appearance in this patient suggested a benign adrenal tumor.

**Dr. John Beal:** The remarks of Doctor Gordon and Doctor Waldstein have clarified the diagnostic considerations in virilization in this patient. The lack of suppression of adrenal hormone excretion after the administration of dexamethasone was excellent evidence for the presence of an adrenal tumor. The venogram localized the lesion and tended to indicate that it was benign. **More than half of adrenal tumors which cause virilism occur in prepubertal patients and more than 80% are in female patients.** Virilizing adrenal tumors are uncommon and are seldom bilateral. For this reason, the patient was operated upon, through a flank approach with removal of the 12th rib. ◀

## COOK COUNTY

### Graduate School of Medicine

#### CONTINUING EDUCATION COURSES

STARTING DATES - 1977

SPECIALTY REVIEW THORACIC SURGERY, February 21  
SPECIALTY REVIEW SURGERY, PART II, March 14  
NEUROLOGY, PART I, BASIC, March 14  
BASIC INTERNAL MEDICINE, One Week, March 14  
NEUROPATHOLOGY, One Week, March 21  
DIAGNOSIS & MANAGEMENT OF PROBLEMS IN GYNECOLOGY, March 21  
BASIC EKG, One Week, March 21  
EKG FOR ANESTHESIOLOGISTS, One Week, March 21  
ADVANCED EKG, Two and a half days, March 28  
BASIC REVIEW PSYCHIATRY, One Week, March 28  
SURGERY OF THE G. I. TRACT, One Week, April 11  
SPECIALTY REVIEW PEDIATRICS, One Week, April 11  
DIAGNOSTIC RADIOLOGY, One Week, April 11  
SPECIALTY REVIEW UROLOGY, One week, April 18  
REVIEW IN MEDICAL GENETICS, Three Days, April 18  
STATE & NAT'L. BD. REVIEW, BASIC, April 24, CLINICAL, May 2  
FAMILY PRACTICE REVIEW, One Week, April 25

Information concerning numerous other continuation courses available upon request.

#### Address:

REGISTRAR, 707 South Wood Street,  
Chicago, Ill. 60612



# Doctor's News

**MIDWEST CLINICAL CONFERENCE**—The 33rd annual Midwest Clinical Conference, sponsored by the Chicago Medical Society and participating specialty societies, is scheduled for March 2-5 at the McCormick Inn, Chicago. Physicians are urged to attend the conference, which will feature a four-day program of scientific sessions and instruction courses, as well as a wide variety of technical exhibits. Scheduled speakers include practitioners and researchers of national and international reknown. The conference has been approved for 25 elective hours of AMA/CME credit. The fee for non-members of the Chicago Medical Society or a participating Chicago specialty society is \$35.00. Half-day instruction courses will require registration fees of \$40.00. For further information, physicians are urged to contact the Midwest Clinical Conference, Chicago Medical Society, 310 S. Michigan Avenue, Chicago, 60604, or telephone (312) 922-0417.

**EXPANDED DRUG ABUSE PROGRAM**—Thomas B. Kirkpatrick, Jr., executive director of the Illinois Dangerous Drugs Commission, has announced that the Commission will submit a plan to increase Illinois drug abuse treatment capacity to the National Institute on Drug Abuse. The monies are allocated, Kirkpatrick said, to communities whose services were inadequate due to financial problems. The proposed program would provide for a total of 325 additional patients divided among Chicago, Elgin, Kankakee, Peoria and Carbondale treatment centers. (NIDA announced expansion of Illinois funding late last year, subject to a viable allocative plan.)

**FIFTH ANNUAL ICCME CONGRESS**—The new mandatory Illinois continuing medical education law will be the subject of the fifth annual ICCME congress, which will be held April 15-16 at the Oak Brook Hyatt House, in Oak Brook, Illinois.

**PERINATAL CARE**—The Chicago Chapter of the National Foundation—March of Dimes has announced a grant of \$85,000 to facilitate a program coordinated under the Illinois Association for Maternal and Child Health. The new program, which will be directed by Dr. James A. O'Leary, professor and chairman of the department of obstetrics and gynecology at Loyola University Medical Center, seeks to upgrade perinatal health care services throughout the Chicago area. Intended to supplement the state Perinatal Program, it will implement multi-disciplinary teams of health care personnel through the six Perinatal Intensive Care Centers in the Chicago area. The teams will provide assistance and expertise for hospitals in that locality.

**ISSUES IN AGING**—An interdisciplinary organization designed to examine theoretical and clinical concepts in aging, has been organized in the Chicago area. George Pollock, M.D., Chicago Institute for Psychoanalysis, Sanford Finkel, M.D., Michael Reese Hospital, and David Gutman, Ph.D., chief of the division of psychology at Northwestern University Institute of Psychiatry, have announced the establishment of the Society for Life Cycle Psychology and Aging. The Society will meet monthly to discuss current issues in geriatric care. Membership is open without charge to Illinois physicians, who may contact Ms. Jackie Miller, (312) 726-6300, for further information.



**NEW CPT ISSUED**—The fourth edition of AMA Current Procedural Terminology is now available to physicians. The AMA is also offering an updating service providing copies of new and revised procedures for insertion in the outdated manual. Interested physicians may obtain the new book (at a cost of \$12) by writing the Order Department, American Medical Association, 535 N. Dearborn Street, Chicago, 60610.

**MENTAL RETARDATION RESEARCH**—Two researchers at Christ Hospital in Oak Lawn may have found a means to end human mental retardation. Sudhir Kumar, Ph.D., director of the perinatal laboratory and Manohar Rath, M.D., a neonatologist, have reported a direct relationship between retardation and an inhibitory chemical normally found in the human brain. Their findings, published in a recent edition of *Neuroscience Letters*, outline the significance of enzymes involved in uric acid and urea production, which influence the level of ammonia present in body tissue. Kumar and Rath have found a complete absence of the chemical in the brains of newborns who have died from acute brain damage and exhibited clinical manifestations of severe mental retardation. They have hypothesized that this absence results in increased ammonia levels in the brain, which research has shown to be a key factor in severe mental retardation.

**ISMS FAR EAST MEDICAL TOUR**—The recent ISMS tour hosting over 100 Illinois physicians and their families through Singapore, Bali and Hong Kong, was proclaimed an educational and recreational success. According to Dr. Wei-Ping Loh, chief pathologist of the Gary Methodist Hospital and clinical professor of pathology at the Chicago Medical School, who served as traveling medical seminar chairman, lectures on topics ranging from tuberculosis to acupuncture treatment for drug addiction were well received by all participants.

**PHYSICIANS IN THE NEWS**—Dr. Allen L. Wright, Chicago, has been named president of the St. Bernard Hospital Medical Staff. The current chairman of the executive committee and the department of orthopedic surgery, Dr. Wright will now coordinate continuing education programs for the hospital, act as a staff-board liaison, and review all applications for staff appointments prior to board recommendation. Marshall A. Falk, Wilmette, has been selected 1976 Distinguished Alumnus of the Chicago Medical School. Dr. Falk is the dean of the Chicago Medical School and a professor of psychiatry. St. Francis Hospital in Evanston, has announced three new appointments on its medical staff. Daniel J. Murphy, M.D., Evanston, will serve as president of the medical and dental staffs at the hospital. Ronald J. Ciskoski, M.D., Skokie, is the president elect for 1977, and John T. Fitzgerald, M.D., Glenview, will serve as secretary-treasurer.

Four more Illinois physicians are scheduled to be named fellows of the American College of Radiology at its annual meeting in April. Leonid Celenoff, Galdino E. Valvassori, and Peter Earl Weinberg, of Chicago as well as Richard Gregg Wilson, Rockford, are scheduled to receive the honor.

# FRAUD



Cornelius Vanderbilt said, "the public be damned" and the public has been damned by misinformation about Medicaid fraud and abuse.

Whether committed by public officials, optometrists, podiatrists, dentists, chiropractors, nursing home operators, "medicaid mills", doctors of osteopathy or doctors of medicine, Medicaid fraud should be considered a felony and prosecuted as such.

Ours seems to have been the only group to do anything significant about this problem in Illinois. We have offered our help to federal and state officials in exposing fraud. We have provided the Medical Disciplinary Act and fought to have it passed and then fought again to override former Governor Walker's veto. Voluntarily, we increased our license renewal fee 400% in order to fund the activities of the Medical Disciplinary Board and its investigative staff. The licenses of these cheats can be suspended or revoked, but this is as far as we can go, and it is not enough. The public has to insist upon more stringent laws and upon the equitable enforcement of laws.

Medicaid cheats survive for three reasons—a criminal justice system which allows a disgraced former vice-president of the United States to go free, a public and a media which treats high ranking government crooks as celebrities, and an ill-informed media which slanders and stereotypes hundreds of thousands of honest and dedicated professionals and blames them all for the transgressions of a very few.

On the following page, you will find a brief summary and chronology of our professional actions. We need no defense. The public needs the facts.

*Joseph H. Skom, M.D.*

Joseph H. Skom, M.D.

## Editorial Comment

When an ethical problem becomes a political issue, truth is seldom the consequence. In a struggle for uniform standards of integrity, battles are often lost in caucus.

The Medicare-Medicaid fraud scandal is one such instance. Despite genuine efforts by the AMA, ISMS and many other medical societies, the actions of a handful of physicians have tainted the reputation of every physician in this country. Governmental response to programs aimed at punishment of Medicare and Medicaid abusers has been weak, and gestures from legal and law enforcement agencies have proven ineffectual. Efforts in peer discipline and towards governmental reform have been lost in the muddle of political rhetoric and media sensationalism.

ISMS has worked for Medicare-Medicaid reform through every possible avenue. Yet, a lack of response from governmental agencies has stymied our best efforts. The record speaks for itself:

1. In 1974, ISMS offered to establish a screening program for prior-to-payment review of physicians' Medicaid bills on ambulatory care. Although ISMS has resubmitted the proposal to IDPA on numerous occasions, "negotiations" have delayed implementation.

2. Responding to a request from former Gov. Walker, ISMS formed 12 review teams, each composed of two physicians, to investigate the 20 highest-volume Medicaid physicians in Illinois. Under the auspices of a committee formed by members of the General Assembly, the governor's health cabinet, and various IDPA health care advisory committee chairmen, the ISMS teams conducted on-site reviews of office practices and medical records. These findings were submitted to IDPA for action. ISMS was never informed of the disposition of these cases. ISMS members also cooperated with IDPA in on-site checks of other high-volume Medicaid physicians, but IDPA action in these cases has never been revealed.

3. In 1975, information gathered by the Society on factoring company fraud, and also material relating to the 20 high-volume Medicaid physicians mentioned above, were provided to the U.S. Senate's Subcommittee on Aging.

4. In 1976, ISMS offered to employ physicians or others to aid IDPA investigation of questionable practices of Medicaid physicians. Designed

to accelerate investigations and reduce the IDPA Medical Advisory Committee backlog of cases, the proposed peer review system would assess questions of competence, ethics and the legitimacy of services and fees. At this writing, IDPA has not responded to the proposal.

5. Later in 1976, ISMS provided a consultant to assist the Legislative Advisory Committee to Public Aid.

6. ISMS requested a meeting with the Illinois Attorney General to initiate investigation of "entrepreneur" clinics and also offer assistance in factoring company investigations. The Attorney General did not respond to this request.

7. In a major victory, state legislation for a new medical disciplinary system was enacted by the general assembly in 1975 after a three year period of support. The legislation was introduced at the request of ISMS, and vigorous lobbying efforts were largely responsible for the override of former Gov. Walker's initial veto.

On the national level, the AMA has equipped state medical societies with two model acts to toughen the disciplinary powers of state licensing boards. License revocations and other disciplinary actions reported by state medical boards jumped from 179 in 1974, to 246 in 1975. In the first eight months of 1976, 335 disciplinary acts were reported by the national federation of licensure boards. Significantly, these boards are staffed almost exclusively by physicians.

This brief overview serves to crystallize the problem. It is clear that efforts by organized medicine at both the state and national level demonstrate a genuine professional concern. Yet, more often than not, suggestions, programs and offers of assistance have been met with bureaucratic postponement. And rhetoric.

The media cannot be blamed for repeating what they are told. Efforts toward a genuine crackdown on Medicare-Medicaid offenders must be continued and intensified. Concomitantly, the public must be informed of these efforts, in order to ensure that pressure is directed toward those who have the power to enforce them. Neglecting either represents social irresponsibility and professional suicide.

*Prepared in conjunction with President's Page  
of Dr. Joseph Skom*

# Alcoholism-Outpatient and Follow-up Treatment in a General Hospital

By HELEN K. COOLEY, B.A./EVERGREEN PARK

*Treatment for the acutely ill alcoholic has been an on-going program at Little Company of Mary Hospital in Evergreen Park for the past two and a half years.<sup>1</sup> Along with the medical management of the illness, a comprehensive outpatient treatment process has been developed to provide the discharged patient with continued professional treatment. Psychotherapists who are specifically trained in treatment of alcoholism work under the direction of a physician,\* to provide an holistic approach to rehabilitation of the alcoholic. Described below is the psychotherapy model, the goals of treatment and a summary of techniques used . . . all of which can be easily adapted to meet the needs of other general hospitals.*

## Overview

This therapy approach treats not only the illness, but also the total individual. By establishing an outpatient psycho-medical framework it is possible to treat the socio-psychological aspects of the patient as well as provide ongoing nutritional and medical monitoring.

This is important because once the symptoms of active acute alcoholism have been removed, it is not uncommon for the patient to present other types of physical symptoms, such as peripheral neuritis, hypo-glycemia, anemia, etc. For effective rehabilitation of the alcoholic, all areas-emotional, social and physical-must be critically assessed and continually reevaluated as the patient progresses in therapy.

## Treatment

To prepare the patient for outpatient treatment, counseling begins on admission to the

hospital. One of the primary purposes of this initial counseling is to help the individual recognize that he has an addictive illness which will require continuing treatment after he is discharged. While the patient is in the hospital he is seen daily by the alcoholism coordinator who develops a supportive relationship and provides the basic introduction to the Alcoholics Anonymous program and follow-up treatment.

The coordinator cooperates with the attending physician and other staff members and reports emotional and attitudinal changes, along with significant observations on behavior. As soon as the patient is physically able, he attends the Tuesday and Thursday therapy-discussion groups and film presentations which are conducted by the coordinator and other staff members trained in alcoholism counseling. Alcoholics Anonymous meetings are held on Monday, Wednesday and Friday of each week. These are attended by members of the general AA community which include many former patients. All physically able inpatients participate in these meetings.

A Saturday therapy workshop serves as a transition point for inpatients into outpatient



HELEN K. COOLEY, B.A., is an alcoholism therapist in the outpatient follow-up treatment program at Little Company of Mary Hospital. Ms. Cooley specializes in alcoholism therapy and family counseling. A part-time teacher in high school psychology at Queen of Peace High School in Burbank, she is currently enrolled in the masters program at the Alfred Adler Institute for Individual Psychology.

\*James W. West, M.D., Assistant Professor, Department of Psychiatry, Rush-Presbyterian-Saint Luke's Medical Center; Director of Alcoholism Services, Little Company of Mary Hospital, Evergreen Park, Illinois.



treatment. This one-hour workshop, facilitated by the outpatient therapist, is structured to:

- provide opportunity for the patients to become familiar with the therapist;
- transmit basic information on alcoholism and addiction;
- supply hope, encouragement and support;
- present the patient with the various tools that are available to facilitate his recovery; and
- provide an atmosphere for non-threatening discussion and interaction.

Patients who are ready for discharge are encouraged to make an appointment with the therapist for a one-to-one evaluation session. They are also directed to return to the Saturday Workshop sessions for at least four weeks in addition to AA and Alanon involvement. Outpatient treatment is designed to meet the specific needs of the individual.

### Outpatient Program

When an outpatient comes for the initial one-to-one session the therapy model is explained in detail. Requirements for therapy participation are clearly presented, the investment of money and time are thoroughly discussed, and guidelines for participation are agreed upon (cancellation of appointments, continuity of attendance, abstinence from alcohol or pills, etc.)

It is explained to the new outpatient that his health is his first priority, and that dollar investment over time is much less costly than the price of alcohol and its destructive side effects.

All patients are held responsible to pay-as-you-go. There is no billing system. It is interesting to note that clients are not only agreeable to this approach, but also feel a sense of relief. Many have felt burdened with a pile up of unpaid bills. This system avoids the continuation of a self-defeating pattern. Common sense, however, indicates that it is the "spirit not the rule" which is important. Clients may be carried without charge when it appears appropriate.

The rationale to the client is given in a straightforward fashion. (1) The alcoholic/addict has always found money for his "favorite pain-killer." Therefore, if he is committed to recovery he will be equally successful in affording his treatment. (2) One of the symptoms of his illness is the mistaken and self-defeating view that "others owe me and can be manipulated to meet my needs;"<sup>2</sup> that is, "something for nothing is the only way I can make it in the

world."<sup>3</sup> Expecting financial accountability to the degree of the client's capability provides him the opportunity to exercise a sorely needed adult dignity and right.

### Saturday Workshop

Once the patient has entered therapy he is seen in individual sessions two to four times during each month. Attendance at Saturday workshop is a required part of his treatment until it is determined that sobriety is stabilized. At this time he is moved into an advanced workshop which focuses on value assessment and self-expression. Regular attendance at workshop is an essential part of the individual's treatment and is included within the cost of the one-to-one sessions. In specific cases the spouse is required to attend workshop also. Workshop participation allows the hospital inpatients to meet informally with people who are in on-going therapy and benefiting from this treatment. Further, it enables the outpatients to use their newly emerging social concern skills. **In other words, therapy is designed to be comprehensive in that during individual sessions the client is focused inward on self in order to understand his own motivations and behavior patterns. During group participation he is focused outward on others to develop a healthy concern for others and avoid introspective preoccupation.**

An intrinsic and required part of the Saturday workshop treatment includes an after-session gathering over coffee. Immediately following workshop all outpatients attend a forty-five minute discussion of the subject which was covered during the workshop. They are encouraged to take issue, disagree or express any annoyance they may have felt during the lecture. All effective facilitators should encourage patients to surface any resentments by providing an atmosphere of permission. This allows the skeptic or malcontent to gain needed attention and also provides an atmosphere for him to alter his psychic position. The absence of the facilitator encourages a certain type of therapeutic freedom to dissent while at the same time other members protect group cohesiveness through empathy and clarification.<sup>4</sup>

Couples counseling is included within the therapy model as a regular part of the treatment program. A couple's session with the alcoholic and spouse is required after the first and not later than the fourth appointment. Family counseling is often indicated in which the whole family con-

stellation comes in for assessment. Often the couple's session becomes an on-going process. At minimum the spouse of the patient is brought to session every six weeks in order to obtain another perspective on the client's progress.

Intrinsic within the modality is AA participation. Generally, each client is required to attend two closed meetings per week and the Sunday open breakfast, to which he is encouraged to take his spouse. This, however, must be determined on an individual basis. Some clients in the primary stages of counseling are of such limited social capability that they express opposition to joining the greater AA community and coercion has proven antitherapeutic. In these cases, AA participation is postponed until the trust bond between therapist and client is established and the client's experiences in the workshop have helped him to develop sufficient social courage to risk the discomfort of the AA group.

### Group Therapy

In addition to individual sessions, workshops, couple and family counseling and AA participation, group therapy also is included in about three-fourths of the clients' treatment program. **It has been found advisable that a strong client-counselor relationship be established, that sobriety be stabilized and that the client be capable of "other-concern" before placing him in a group.** This determination is made by assessing the client's psychic method of operation, hidden goals<sup>5</sup> and present degree of cooperation in session and workshop.

During the past year two psychotherapy groups were graduated after eleven months. A six month basic counseling group which included clients who had stabilized but who were not appropriate candidates for psychotherapy was also completed. The ability to conceptualize, abstract, generalize and synthesize appears to be an essential prerequisite to meaningful participation in intensive psychotherapy.

The basic counseling group worked on specific personality problems in their external form, such as shyness in groups, lack of decision making capability, confused identification of personal feelings and inappropriate emotional responses. This was then correlated with their individual life-management problems, with the therapeutic focus on redirection of outward behavior.

The psychotherapy groups, while doing all of the above, dedicated more energy to exploring personality dynamics, such as double-bind circular behavior traps, hidden lines of movement,

unattended goals of superiority and inferiority and psychological pay-offs. The focus was understanding of private logic and rearranging of internal life plan, as opposed to the less difficult therapeutic task of external redirection.

### General Goals of Outpatient Therapy

In the early stage of treatment the role of the counselor is supportive and aims to uncover any residual denial patterns in the patient's acceptance of his illness. The first and primary goal before any other therapeutic work can proceed is to help client stabilize his sobriety. This is accomplished through building a trust bond with the patient, monitoring his AA participation and workshop interaction. Developing out of this is the second goal, which is to help the patient become comfortable and highly involved in the greater AA community. A third goal is to help the client develop a variety of responses to external world situations that will increase his freedom to experience life fully—not only within the protected confines of Alcoholics Anonymous, but also in the world-at-large.

A final goal, and one that appears difficult to reach without professional therapy, deals with the development of flexibility.<sup>6</sup> Flexibility is essential to allow the client to build his autonomy and avoid what can accurately be termed, "return to primitive sobriety."

Primitive sobriety is a vital and necessary stage that each patient or AA member must experience. During this initial stage of sobriety, the alcoholic's primary task is to mobilize all his courage to "not drink for one day." This is a surrender that lets him know he is victorious. It is a battle that he must win if he is to stay alive and go forward. It has been observed, however, that once this battle is won many AA members cling to that courageous victory and do not have the additional courage (or possibly the know-how) to move forward. The alcoholic who was at one time constantly preoccupied with drink becomes equally preoccupied with *not* drinking—even years after he has had his last battle with the bottle. These sober alcoholics of some duration become "stuck" into a rigid pattern that negates the possibility for further growth.

When new life tasks require attending to it is not uncommon for some recovering AA members to perceive the need for change not as an exciting challenge, but rather as a hostile threat. This is apparent when the AA member, instead of exploring different solutions and trying new

alternatives, evades the real problems by remaining in, or returning to the primitive stage of sobriety. By doing this he is able to justify his evasion by expending feverish energy in his preoccupation with "just not drinking today." This is a smokescreen—an unrealized diversionary tactic—to avoid dealing with the real issues of his discontent. In these cases it appears that it is easier to fight a battle already won than to accept the new challenge where the outcome is not known. This type of recovering alcoholic tends to limit his world to a small safe corner and console himself that "at least I'm sober today," instead of engaging in active present-day problem solving. He asks himself not "what can I do to make my life more satisfying and meaningful?" but rather, "how can I be safe?" At best these people have a discontended and limited existence in which their creative energy is diverted into *evading* life's tasks. And most tragic is that many do return to drink! This happens, not from a compulsion (an alcoholic "creates" a compulsion as an avoidance technique), but because of the fearful wish to evade the new challenges that life presents.

In achieving realistic flexibility to try new alternatives the client is able to leave therapy, freed not only from the symptoms of drink, but also from the need to create new symptoms, such as continual preoccupation with primitive sobriety. He is then not only able to contribute to the AA community in healthy ways, but also to cooperate with the greater world in meeting life tasks.

### Techniques

To help the client in self-interpretation and behavior modification, a variety of tools and skills are used. The focus in the therapy model, as previously stated, considers the total individual and always respects each person's particular uniqueness. The emphasis in this treatment is on health, not on sickness. "You are well and getting better," is our standard motto.

Once sobriety is stabilized a person in treatment is no longer referred to as a patient, but is labeled as a client, which expresses an equality of worth and also defines the nature of the counselor's role with the client. **This therapy model posits a mutual responsibility between client and therapist to work, but emphasizes the client's own capability of healthy self-direction.** In following Carl Rogers' practical approach toward therapy, it is assumed that the individual has the inherent capacity for making

wholesome decisions on his own behalf.<sup>9</sup> In other words, there are no sick clients, but only courageous people working to improve the quality of their lives. The aspects of client responsibility and choice are a major focus within this model.

Among the essential tools used for assessing the patient is the drinking profile which indicates the stage of progression of the addiction. Complete social histories are taken, including family constellation and early recollections.<sup>10</sup> Detailed notes on each individual and group session including periodic summary evaluations are of vital importance in the continuity of treatment. To insure comprehensive treatment the therapist must spend adequate time outside of sessions reviewing the histories, keeping systematic records and making preparation for the client's on-going treatment.

Adlerian Individual Psychology has proven the most beneficial framework for helping the client to develop the healthy spark of social interest which is in everyone, albeit at times well hidden. It provides effective methods of insight building which enable clients to successfully tackle the universal life tasks.<sup>11</sup> By focusing on cooperation instead of competitive striving to be superior, realistic problem solving becomes possible.<sup>12</sup>

One tool which is regularly used and out of which a variety of session activities have been developed is the "Helping Person" sheet, which was developed from Truax and Carkhuff's research on the indicators of an effective helping person. This tool provides guidelines which give the client a clear and systematic model of emotional health and serves as a convenient check list for self-evaluation.

### Summary

To ensure an effective system of care for the acutely ill alcoholic the treatment process at Little Company of Mary Hospital is intrinsically linked to the broader area-wide alcoholism network of treatment programs. This provides a variety of community resources that may be included within the individual prescribed treatment. By involving the discharged alcoholic patient in an holistic follow-up treatment system, it is usually not necessary for the alcoholic to be confined in a long-term alcoholism rehabilitation unit. This outpatient model can easily be adapted by any general hospital in order to meet the needs of its particular community. Through



▲

1. West, James W., M.D. "Alcoholism-A General Hospital Meets the Challenge," *Illinois Medical Journal*, June 1973, pp. 96-99.
2. James, M.; Jongeward, D. "Winners and Losers," BORN TO WIN, Philippines: Addison-Wesley Publ. Co., 1973. pp. 1-6.
3. Beecher, W.; Beecher, M. "The Manipulators," BEYOND SUCCESS AND FAILURE, New York: Simon and Schuster, Inc., 1975. pp. 87-91.

4. Yalom, Irvin D. "Group Cohesiveness," *THE THEORY AND PRACTICE OF GROUP PSYCHOTHERAPY*, New York: Basic Books, Inc., 1973. pp. 53-56.
5. Shulman, Bernard H., M.D., "Life Style," *CONTRIBUTIONS TO INDIVIDUAL PSYCHOLOGY*. Chicago: Alfred Adler Institute, 1973. pp. 16-25.
6. Ansbacher, H. L.; Ansbacher, R. R. "The Antithetical Mode of Apperception," *THE INDIVIDUAL PSYCHOLOGY OF ALFRED ADLER*. (excerpt from section on "The Neurotic Disposition") New York: Harper Torchbooks, Harper & Row Publ., 1967. pp. 248-249.
7. *Ibid.*, "Exclusion Tendency," (excerpt from section on "Neurotic Safeguarding Behavior.") pp. 277-279.
8. Op. cit. Beecher, W.; Beecher, M. "Main Tent vs. Side Shits."
9. Rogers, Carl R. "The Attitude and Orientation of the Counselor," *CLIENT-CENTERED THERAPY*. Boston: Houghton Mifflin Co., 1951. pp. 19-64.
10. Adler, Alfred "Early Memories," *WHAT LIFE SHOULD MEAN TO YOU*. New York: Capricorn Books, G. P. Putnam's Sons, 1958. pp. 71-92.
11. Op. cit. Ansbacher, H. L.; Ansbacher, R. R. "Social Interest."
12. Op. cit. Beecher, W. "Competition."
13. Wolf, Sidney "Bedside Manner: For Better or Worse," *Maryland State Medical Journal*, June 1973.

This week get away from it all! Lake Lawn Lodge has the restful atmosphere you need to unwind. Call Chicago (312) 372-6062 for reservations, or call or write us directly.



Box M, Delavan, WI 53115  
Phone 414/728-5511





# ISMS Guide to Continuing Medical Education

Compiled for Illinois physicians by the  
ILLINOIS COUNCIL ON CONTINUING MEDICAL EDUCATION  
55 E. Monroe St., Suite 3510 • Chicago, IL 60603 • (312) 236-6110



Items for this Calendar must be received 90 days prior to the event. Those received earlier may appear in up to three monthly issues.

**WARNING!** Items for this Calendar come from many sources, often far in advance of the publication date. Sometimes, cancellations or changes in date, place or time occur too late to be corrected before publication. You are urged to contact the sponsoring organization to confirm information given below.

## MARCH

### Anesthesiology

#### ENG FOR ANESTHESIOLOGISTS

For: Anesthesiologists. Lecture and equipment demonstration. March 21 (for 5 days). Cook County Graduate School of Medicine, Chicago. Speaker: Alan P. Winnie, M.D. (Coordinator). CME Credit: 35 hrs. AMA Cat. 1. Fee: \$200. Reg. Limit: 35. Sponsor, contact: Cook County Graduate School of Medicine, 707 S. Wood St., Chicago, IL 60612. Attn: Robert J. Baker, M.D., Dean. Telephone: (312) 733-2800.

### Antibiotics Used in Infectious Diseases

**NEWER ANTIBIOTICS AND INFECTIOUS DISEASE**  
For: Interns, Residents, Attending. Lecture. March 11, 11:00 am-12 noon (buffet luncheon). Martha Washington Hospital, Chicago. Speaker: William L. Hewitt, M.D., University of California. CME Credit: 1 hr. AMA Cat. 1. Fee: None. Sponsor, contact: Martha Washington Hospital, 4055 N. Western Ave., Chicago, 60618. Attn: Fernando Villa, M.D., Medical Director. Telephone: (312) 583-9000. Co-sponsor: Smith Kline & French Laboratories and Medical Staff of Martha Washington Hospital.

### Clinical Ophthalmology

#### WEEKLY CLINICAL CASE CONFERENCE

For: Ophthalmologists. All Wednesdays throughout year, 4:00-6:00 pm. University of Illinois, Eye & Ear Infirmary, Chicago. Speaker: Morton F. Goldberg, M.D., Prof. & Head of Ophthalmology Dept., Univ. of Illinois. CME Credit: 2 hrs. per week AMA Cat. 1. Fee: None. Sponsor, contact: University of Illinois, Dept. of Ophthalmology, 1855 W. Taylor St., Chicago, 60612. Attn: Mrs. Cecile Wege, Secy. for Cont. Educ. Telephone: (312) 996-6590.

### Family Medicine, Gynecology

#### DIAGNOSIS & MANAGEMENT OF PROBLEMS IN GYNECOLOGY

For: Gynecologists. Family Practice physicians. Lecture. March 21 (for 5 days). Cook County Graduate School of Medicine, Chicago. Speaker: John G. Masteron, M.D. (Coordinator). CME Credit: 38 hrs. AMA Cat. 1. AAFP Prescribed. Fee: \$200. Reg. Limit: 100. Sponsor, contact: Cook County Graduate School of Medicine, 707 S. Wood St., Chicago, IL 60612. Attn: Robert J. Baker, M.D., Dean. Telephone: (312) 733-2800.

### Electrocardiography

#### ADVANCED ELECTROCARDIOGRAPHY

For: Internists, Cardiologists. Lecture. March 28 (for 2½ days). Cook County Graduate School of Medicine, Chicago. Speaker: Kenneth Rosen, M.D. (Coordinator). CME Credit: 17 hrs. AMA Cat. 1. Fee: \$125. Reg. Limit: 75. Sponsor, contact: Cook County Graduate School of Medicine, 707 S. Wood St., Chicago, IL 60612. Attn: Robert J. Baker, M.D., Dean. Telephone: (312) 733-2800.

### Family Medicine

#### BASIC INTERNAL MEDICINE

For: General or part-time specialty. Lecture. March 14 (for 5 days). Cook County Graduate School of Medicine, Chicago. Speaker: Sheldon S. Waldstein, M.D. (Coordinator). CME Credit: 40 hrs. AMA Cat. 1. AAFP Prescribed. Fee: \$200. Reg. Limit: 100. Sponsor, contact: Cook County Graduate School of Medicine, 707 S. Wood St., Chicago, IL 60612. Attn: Robert J. Baker, M.D., Dean. Telephone: (312) 733-2800.

### Family Practice, Medicine

#### BASIC ELECTROCARDIOGRAPHY

For: Physicians interested in electrocardiographic interpretation. Lecture. March 21 (for 5 days). Cook County Graduate School of Medicine. Speaker: Kenneth Rosen, M.D. (Coordinator). CME Credit: 35 hrs. AMA Cat. 1. AAFP Prescribed. Fee: \$200. Reg. Limit: 45. Sponsor, contact: Cook County Graduate School of Medicine, 707 S. Wood St., Chicago, IL 60612. Attn: Robert J. Baker, M.D., Dean. Telephone: (312) 733-2800.

### Family Therapy

#### PERSONAL/PROFESSIONAL GROWTH WORKSHOP FOR THERAPISTS; WITH OR WITHOUT PARTNERS

For: Physicians and Mental Health Professionals. Three-day workshop. March 3, 7:30 PM-10:30 PM; March 4, 9:00 AM-9:00 PM; March 5, 9:00 AM-1:00 PM. Oak Park. Speakers: Charles H. Kramer, M.D., and Jeannette Karm. F.I.C./C.F.S., NMH & NIMS. CME Credit: 19 hrs. AMA Cat. 1. Fee: \$225. Individual: \$200. Couple: Reg. Limit: 15. Sponsor, contact: The Family Institute of Chicago/Center for Family Studies, 10 E. Huron, Chicago, IL 60611. Attn: Belinda M. Stone. Telephone: (312) 440-1414. Co-sponsor: Northwestern Memorial Hospital & Northwestern University Medical School.

#### ANNUAL SPRING CONFERENCE: WORKING WITH BLACK FAMILIES

For: Physicians and Mental Health Professionals. Two-day workshop. March 18-19, 9:30 AM-4:30 PM both days. Northwestern University. Speaker: Robert B. Hill, Ph.D., Urban League, Washington, D.C.; Peter Uchman, Philadelphia Child Guidance Clinic. CME Credit: 14 hrs. AMA Cat. 1. Fee: \$70. Sponsor, contact: The Family Institute of Chicago/Center for Family Studies, 10 E. Huron, Chicago, IL 60611. Attn: Belinda M. Stone. Telephone: (312) 440-1414. Co-sponsors: Northwestern Memorial Hospital & Northwestern University Medical School.

### Geriatrics/Long-Term Care

#### BREAKING THE SILENCE BARRIER: UPGRADING SERVICES TO NURSING HOME PATIENTS WITH COMMUNICATION DISORDERS

For: Medical Directors of Long Term Care Facilities and other professionals involved in provision of services to communicatively impaired. March 22-23, 8:30 am-4:30 pm. Conrad Hilton Hotel, Chicago. CME Credit: 14 hrs. AMA Cat. 2. Fee: \$25. Reg. Limit: 100. Reg. Deadline: March 4 (late registration \$35). Sponsor, contact: American Speech & Hearing Assoc./Illinois Speech & Hearing Assoc., 9030 Old Georgetown Road, Washington, D.C., 20014. Attn: Geri Wright, Lundberg, Telephone: (312) 975-3454.

### Laparoscopy/Obstetrics and Gynecology

#### LAPAROSCOPY, OPEN LAPAROSCOPY, FETOSCOPY, AND HYSTEROSCOPY

For: Gynecologic laparoscopists. Postgraduate course; three full day sessions with demonstrating in OR. March 30, 31, and April 1, 8:30 AM-5:00 PM. Northwestern Memorial Hospital, Chicago. Speaker: Director: Dr. Melvin R. Cohen. CME Credit: This course has been approved for 30 cognates by the Am. College of Obstetrician and Gynecologists. Fee: \$400. Residents and fellows \$175. Reg. Deadline: March 1. Reg. Limit: 60. Sponsor, contact: Northwestern University Medical School, Section of Graduate and Continuing Education, NIMS, Dept. of Obstetrics and Gynecology, 333 E. Superior St., Room 600C, Chicago, IL 60611. Attn: Valerie Vance. Telephone: (312) 649-7508. Co-sponsor: Am. Association of Gynecologic Laparoscopists.

### Midwest Clinical Conference

#### 33rd ANNUAL MIDWEST CLINICAL CONFERENCE

For: All physicians. Clinical conference. March 2, 3, 4, and 5, 9:00 AM-5:00 PM. Saturday 9:00 AM-Noon. McCormick Inn, Chicago. CME Credit: 25 hrs. AMA Cat. 1. AAFP Elective. Fee: \$35 non-members. Sponsor, contact: Chicago Medical Society, 310 S. Michigan Ave., Suite 1616, Chicago, IL 60604. Attn: Judy Madel. Telephone: (312) 922-0417. Co-sponsor: Participating Specialty Societies.

### MUSCULOSKELETAL TRAUMA

For: Physicians. Clinical hospital program on Trauma. March 15, 8 PM-10 PM. Highland Park Hospital. Speakers: To be announced. CME Credit: 2 hrs. AMA Cat. 1. AAFP Elective. Fee: None. Sponsor, contact: Chicago Committee on Trauma of the American College of Surgeons, 11255 W. 74th St., LaGrange, IL 60525. Attn: Mrs. Lillian Hush. Telephone: (312) 246-3788 or 482-8566.

### Neurology

#### REVIEW IN NEUROLOGY. PART 1. BASIC

For: Neurologists, Psychiatrists. Lecture. March 14 (for 5½ days). Cook County Graduate School of Medicine, Chicago. Speaker: Catherine Haberland, M.D., Coordinator. CME Credit: 44 hrs. AMA Cat. 1. Fee: \$225. Reg. Limit: 80. Sponsor, contact: Cook County Graduate School of Medicine, 707 S. Wood St., Chicago, IL 60612. Attn: Robert J. Baker, M.D., Dean. Telephone: (312) 733-2800.

### Pediatrics

#### RETICULOENDOTHELIOSIS; OTHER PEDIATRIC NEOPLASMS

For: All interested physicians. Lecture series. March 2, 9:00 am. St. Joseph Hospital, Chicago. Speaker: Edward Baum, M.D. CME Credit: 1 hr. AMA Cat. 1. Fee: None. Sponsor, contact: St. Joseph Hospital, Office of Medical Education, 2900 N. Lake Shore Drive, Chicago, 60657. Attn: Tina Dabrowski. Telephone: (312) 975-3454. Co-sponsor: Mead Johnson.

#### MENINGITIS

For: All interested physicians. Lecture series. March 15, 9:00 am. St. Joseph Hospital, Chicago. Speaker: A. Todd Davis, M.D. CME Credit: 1 hr. AMA Cat. 1. Fee: None. Sponsor, contact: St. Joseph Hospital, 2900 N. Lake Shore Drive, Chicago, 60657. Attn: Tina Dabrowski. Telephone: (312) 975-3454. Co-sponsor: Senator Everett McKinley Dirksen Memorial Fund.

### Pediatrics

#### INTRAUTERINE VIRAL INFECTION

For: All interested physicians. Lecture series. March 15, 9:00 am. St. Joseph Hospital, Chicago. Speaker: A. Todd Davis, M.D. CME Credit: 1 hr. AMA Cat. 1. Fee: None. Sponsor, contact: St. Joseph Hospital, 2900 N. Lake Shore Drive, Chicago, 60657. Attn: Tina Dabrowski. Telephone: (312) 975-3454. Co-sponsor: Senator Everett McKinley Dirksen Memorial Fund.

#### EXANTHEMS & IMMUNIZATION

For: All interested physicians. Lecture series. March 30, 9:00 am. St. Joseph Hospital, Chicago. Speaker: A. Todd Davis, M.D. CME Credit: 1 hr. AMA Cat. 1. Fee: None. Sponsor, contact: St. Joseph Hospital, 2900 N. Lake Shore Drive, Chicago, 60657. Attn: Tina Dabrowski. Telephone: (312) 975-3454. Co-sponsor: Senator Everett McKinley Dirksen Memorial Fund.

#### FUO

For: All interested physicians. Lecture series. March 30, 9:00 am. St. Joseph Hospital, Chicago. Speaker: A. Todd Davis, M.D. CME Credit: 1 hr. AMA Cat. 1. Fee: None. Sponsor, contact: St. Joseph Hospital, 2900 N. Lake Shore Drive, Chicago, 60657. Attn: Tina Dabrowski. Telephone: (312) 975-3454. Co-sponsor: Senator Everett McKinley Dirksen Memorial Fund.

### Psychiatry

#### INSIDE-OUTSIDE: GETTING CLOSER

For: Professionals and Students in the Health Field. Lecture. March 2, 7:30-9:30 PM. Forest Hospital Professional Center, Des Plaines. Speaker: Milton H. Miller, M.D., Professor and Head of the Dept. of Psychiatry, Univ. of British Columbia. CME Credit: 2 hrs. AMA Cat. 1. Fee: \$15 (prof.); \$5 (students). Reg. Limit: 100. Reg. Deadline: advance registration required. Sponsor, contact: Forest Hospital Foundation, 5555 Wilson Lane, Des Plaines, IL 60016. Attn: Leo Jacobs, M.D., Director of Medical Education. Telephone: (312) 827-8811.

**CHILDREN OF THE SEXUALLY ATYPICAL**  
 For: Psychiatrists. Annual Dinner/Lecture. March 9, 8:00 pm. Drake Hotel, Chicago. Speaker: Richard Green, M.D., State University of New York. Fee: \$150/00/ticket. Reg. Deadline: March 1. Sponsor, contact: Illinois Psychiatric Society, 55 E. Monroe, Suite 3510, Chicago, 60603. Attn: Wendy Smith. Telephone: (312) 733-1654.

**BIOENERGETICS**  
 For: Mental health care professionals. Lecture March 16, 1:00-4:00 PM. Riveredge Hospital, Forest Park. Speaker: Alexander Lowen, Ph.D., Bioenergetics Analyst, New York. CME Credit: 3 hrs. AMA Cat. 1. Fee: \$10. Reg. Limit: 200. Reg. Deadline: Reservations (771-7000 ext. 342). Sponsor, contact: Riveredge Hospital, 8311 W. Roosevelt Road, Forest Park, IL 60130. Attn: John Pontarelli, Community Relations. Telephone: (312) 771-7000 ext. 305.

**QUALIFICATIONS FOR CLINICAL COMPETENCE IN PSYCHIATRY**  
 For: Psychiatrists. Distinguished lecture series. March 16, 8:00 PM. Passavant Hospital, Chicago. Speaker: S. Mouchley Small, M.D., Professor and Chairman, Dept. of Psychiatry, State U. of New York at Buffalo. CME Credit: 1 1/2 hrs. AMA Cat. 1. Fee: \$200. Sponsor, contact: Institute of Psychiatry, Northwestern University Medical School, 320 East Huron, Chicago, IL 60611. Attn: Jeanne Smith. Telephone: (312) 649-8058.

**Surgery**  
**SPECIALTY REVIEW COURSE IN SURGERY, PART II**  
 For: Surgeons. Lecture. March 14 (for two weeks). Cook County Graduate School of Medicine, Chicago. Speaker: Robert J. Baker, M.D., (Coordinator). CME Credit: 99 hrs. AMA Cat. 1. Fee: \$400. Reg. Limit: 200. Sponsor, contact: Cook County Graduate School of Medicine, 707 S. Wood St., Chicago, 60612. Attn: Robert J. Baker, M.D., Dean. Telephone: (312) 733-2800.

## APRIL

**Family Medicine**  
**FAMILY PRACTICE REVIEW**  
 For: Primary Family Practitioners. Lecture. April 25-One Week-8:30 am. Cook County Graduate School of Medicine, Chicago. Speaker: Sheldon S. Waldstein, M.D. (Coordinator). CME Credit: 45 hrs. AMA Cat. 1. Fee: \$200. Reg. Limit: 125. Sponsor, contact: Cook County Graduate School of Medicine, 707 S. Wood St., Chicago, 60612. Attn: Robert J. Baker, M.D., Dean. Telephone: (312) 733-2800.

**Heart Surgery**  
**HEART SURGERY-PAST, PRESENT AND FUTURE**  
 For: M.D.'s of special interest to cardiovascular surgery residents, etc. CME April 1. Martha Washington Hospital, Chicago. Speaker: Sheldon S. Waldstein, M.D. AAFP. Fee: None. Reg. Limit: 100. Reg. Deadline: March 31. Sponsor, contact: Martha Washington Hospital, 4055 N. Western Ave., Chicago, 60618. Attn: Forman, M.D., Medical Director. Telephone: (312) 583-9000 ext. 331.

**Medical History**  
**D. J. DAVIS LECTURE IN MEDICAL HISTORY: MEDICINE ON STAGE: VAUDEVILLE AND THE MEDICAL PROFESSION 1900-1920**  
 For: All interested in Medical History. Lecture. April 6, 12:30 pm. Univ. of Ill. College of Medicine, Chicago. Speaker: Dr. Allen G. Dubus, Univ. of Chicago. Fee: None. Sponsor, contact: University of Illinois College of Medicine, Div. of Urology, U. of Ill. at the Med. Ctr., P.O. Box 6998, Chicago, 60680. Attn: Dr. J. H. Kiefer. Telephone: (312) 956-6771 (Miss Wilcox).

**Medicine**  
**STATE & NATIONAL BOARD REVIEW (BASIC)**  
 For: Internists & Foreign Medical Graduates. Lecture. April 24-6 1/2 days-1:00 pm. Cook County Graduate School of Medicine, Chicago. Speaker: Sheldon S. Waldstein, M.D. (Coordinator). CME Credit: 53 hrs. AMA Cat. 1. Fee: \$225. Reg. Limit: 150. Sponsor, contact: Cook County Graduate School of Medicine, 707 S. Wood St., Chicago, 60612. Attn: Robert J. Baker, M.D., Dean. Telephone: (312) 733-2800.

**Pediatrics**  
**EVALUATION OF RECURRENT INFECTIONS**  
 For: All interested physicians. Lecture series. April 6, 9:00 am. St. Joseph Hospital, Chicago. Speaker: A. Todd Davis, M.D. CME Credit: 1 hr. AMA Cat. 1. Fee: None. Sponsor, contact: St. Joseph Hospital, 2900 N. Lake Shore Drive, Chicago, 60657. Attn: Tina Dabrowski. Telephone: (312) 975-3454. Co-sponsor: Senator Everett McKinley Dirksen Memorial Fund.

**SPECIALTY REVIEW COURSE IN PEDIATRIC SURGERY**  
 For: Pediatricians (Prep. for Board). Lecture. April 11, 9:00 am, 5 days. Cook County Graduate School of Medicine, Chicago. Speaker: Irvin M. Bush, M.D. (Coordinator). CME Credit: 38 hrs. AMA Cat. 1. Fee: \$225. Reg. Limit: 85. Sponsor, contact: Cook County Graduate School of Medicine, 707 S. Wood St., Chicago, 60612. Attn: Robert J. Baker, M.D., Dean. Telephone: (312) 733-2800.

**OB-GYN**  
**OTITIS MEDIA, URINARY TRACT INFECTIONS, OSTEOMYELITIS**  
 For: All interested physicians. Lecture series. April 13, 9:00 am. St. Joseph Hospital, 2900 N. Lake Shore Drive, Chicago. Speaker: A. Todd Davis, M.D. CME Credit: 1 hr. AMA Cat. 1. Fee: None. Sponsor, contact: St. Joseph Hospital, 2900 N. Lake Shore Drive, Chicago, 60657. Attn: Tina Dabrowski. Telephone: (312) 975-3454. Co-sponsor: Senator Everett McKinley Dirksen Memorial Fund.

**"RECENT CHANGES IN THE STRUCTURE OF THE FAMILY"**  
 For: Mental health care professionals. Lecture. April 20, 1:00 PM-4:00 PM. Riveredge Hospital, Forest Park. Speaker: Bruno Bettelheim, Ph.D., Director Emeritus, Tonia Shankman, Orthogenic School of Chicago, 60657. Attn: Tina Dabrowski. Telephone: (312) 771-7000 ext. 342. Sponsor, contact: Riveredge Hospital, 8311 W. Roosevelt Road, Forest Park, IL 60130. Attn: John Pontarelli. Telephone: (312) 771-7000 ext. 305.

**Surgery**  
**SURGERY OF THE G.I. TRACT**  
 For: Surgeons. Lecture. April 11, 8:00 am—One Week. Cook County Graduate School of Medicine, Chicago. Speaker: Robert J. Baker, M.D. (Coordinator). CME Credit: 40 hrs. AMA Cat. 1. Fee: \$200. Reg. Limit: 200. Sponsor, contact: Cook County Graduate School of Medicine, 707 S. Wood St., Chicago, 60612. Attn: Robert J. Baker, M.D., Dean. Telephone: (312) 733-2800.

**Urology**  
**SPECIALTY REVIEW IN UROLOGY (PREP. FOR BOARD)**  
 For: Urologists. Lecture. April 20, 8:00 am—4 days. Cook County Graduate School of Medicine, Chicago. Speaker: Irving M. Bush, M.D. (Coordinator). CME Credit: 32 hrs. AMA Cat. 1. Fee: \$175. Reg. Limit: 125. Sponsor, contact: Cook County Graduate School of Medicine, 707 S. Wood St., Chicago, 60612. Attn: Robert J. Baker, M.D., Dean. Telephone: (312) 733-2800.

**MAY**  
**Anesthesia**  
**SPECIALTY REVIEW COURSE IN ANESTHESIOLOGY**  
 For: Anesthesiologists. Lecture. May 21, 9:00 am—One week. Cook County Graduate School of Medicine, Chicago. Speaker: Alton P. Winnie, M.D. (Coordinator). CME Credit: 40 hrs. AMA Cat. 1. Fee: \$200. Reg. Limit: 300. Sponsor, contact: Cook County Graduate School of Medicine, 707 S. Wood St., Chicago, 60612. Attn: Robert J. Baker, M.D., Dean. Telephone: (312) 733-2800.

**REGIONAL ANESTHESIA & THERAPEUTIC NERVE BLOCKING**  
 For: Anesthesiologists. Lecture. May 30, 9:00 am—One week. Cook County Graduate School of Medicine, Chicago. Speaker: Vincent J. Collins, M.D. (Coordinator). CME Credit: 40 hrs. AMA Cat. 1. Fee: \$300. Reg. Limit: 8. Sponsor, contact: Cook County Graduate School of Medicine, 707 S. Wood St., Chicago, 60612. Attn: Robert J. Baker, M.D., Dean. Telephone: (312) 733-2800.

**Dermatology**  
**SPECIALTY REVIEW COURSE IN DERMATOLOGY**  
 For: Dermatologists. Lecture. May 2, 9:00 am—One week. Cook County Graduate School of Medicine, Chicago. Speaker: Marshall Blankenship, M.D. (Coordinator). CME Credit: 35 hrs. AMA Cat. 1. Fee: \$200. Reg. Limit: 75. Sponsor, contact: Cook County Graduate School of Medicine, 707 S. Wood St., Chicago, 60612. Attn: Robert J. Baker, M.D., Dean. Telephone: (312) 733-2800.

**Medicine**  
**STATE & NATIONAL BOARD REVIEW (CLINICAL)**  
 For: Internists & Primarily for Family Physicians. Lecture. May 2, 8:00 am—6 days. Cook County Graduate School of Medicine, Chicago. Speaker: Sheldon S. Waldstein, M.D. (Coordinator). CME Credit: 53 hrs. AMA Cat. 1. Fee: \$225. Reg. Limit: 150. Sponsor, contact: Cook County Graduate School of Medicine, 707 S. Wood St., Chicago, 60612. Attn: Robert J. Baker, M.D., Dean. Telephone: (312) 733-2800.

**SPECIALTY REVIEW COURSE IN INTERNAL MEDICINE, CERTIFYING (PREP. FOR BOARD)**  
 For: Internists. Lecture. May 1 and May 15, 1:00 pm—One week. Cook County Graduate School of Medicine, Chicago. Speaker: Sheldon S. Waldstein, M.D. (Coordinator). CME Credit: 64 hrs. AMA Cat. 1. Fee: \$250. Reg. Limit: 550. Sponsor, contact: Cook County Graduate School of Medicine, 707 S. Wood St., Chicago, 60612. Attn: Robert J. Baker, M.D., Dean. Telephone: (312) 733-2800.

**Musculoskeletal Trauma**  
**MUSCULOSKELETAL TRAUMA**  
 For: Surgeons. Clinical program on Trauma. May 12, 8:00-10:00 pm. John B. Murphy Auditorium, 50 East Erie St., Chicago. CME Credit: 2 hrs. AMA Cat. 1. AAFP. Lecture. Fee: None. Sponsor, contact: Chicago Committee on Trauma of the American College of Surgeons, 11255 W. 74th St., La Grange, IL 60525. Attn: Mrs. Lillian Hua. Telephone: (312) 246-3783 or 492-8086. Co-sponsor: Rush-Presbyterian-St. Luke's Hospital.

**SPECIALTY REVIEW COURSE IN OBSTETRICS & GYNECOLOGY**  
 For: Gynecologists and Obstetricians. Lecture. May 16, 8:00 am—ten weeks. Cook County Graduate School of Medicine, Chicago. Speaker: John G. Masterson, M.D. (Coordinator). CME Credit: 83 hrs. AMA Cat. 1. Fee: \$375. Reg. Limit: 125. Sponsor, contact: Cook County Graduate School of Medicine, 707 S. Wood St., Chicago, 60612. Attn: Robert J. Baker, M.D., Dean. Telephone: (312) 733-2800.

**Pain Management**  
**CURRENT CONCEPTS IN PAIN MANAGEMENT**  
 For: Physicians and Allied Health Professionals. Symposium. May 12-14 (8:00 am-5:45 pm). Ambassador West Hotel, Chicago. Speaker: Eugene J. Rogers, M.D., F.A.C.P. CME Credit: 16 hrs. AMA Cat. 1. Fee: \$100. Reg. Limit: 150. Reg. Deadline: March 15. Sponsor, contact: Chicago Medical School, Dept. Rehabilitation Medicine, 2020 W. Ogden Ave., Chicago, 60612. Attn: Eugene J. Rogers, M.D., F.A.C.P. Telephone: (312) 226-4100 ext. 350. Co-sponsor: Veterans Administration Hospital at N. Chicago.

**Psychiatry**  
**GROUP PSYCHOTHERAPY AND THE "NEW" PSYCHOTHERAPISTS**  
 For: Mental health care professionals. Lecture. May 18, 1:00-4:00 pm. Riveredge Hospital, Forest Park. Speaker: Max Rosenbaum, Ph.D., Author of "Intensive Group Experiences". CME Credit: 3 hrs. AMA Cat. 1. Fee: \$10. Reg. Limit: 200. Reg. Deadline: Reservations (771-7000 ext. 342). Sponsor, contact: Riveredge Hospital, 8311 W. Roosevelt Road, Forest Park, IL 60130. Attn: John Pontarelli. Telephone: (312) 771-7000 ext. 305.

**QUEST FOR PURPOSE IN PSYCHIC RESEARCH**  
 For: Psychiatrists. Distinguished lecture series. May 18, 8:00 pm. Passavant Hospital, Chicago. Speaker: Stanley R. Dean, M.D., Stanley R. Dean Fund for Cat. 1. Fee: None. Sponsor, contact: Institute of Research in Psychiatry, Northwestern University Medical School, 320 East Huron, Chicago, 60611. Attn: Jeanne Smith. Telephone: (312) 649-8058.

**Radiology**  
**REFRESHER COURSE IN RADIATION SCIENCE**  
 For: Radiologists. Lecture. May 16, 8:00 am—7 days. Cook County Graduate School of Medicine, Chicago. Speaker: Theodore Fields, M.S. (Coordinator). CME Credit: 60 hrs. AMA Cat. 1. Fee: \$375. Reg. Limit: 75. Sponsor, contact: Cook County Graduate School of Medicine, 707 S. Wood St., Chicago, 60612. Attn: Robert J. Baker, M.D., Dean. Telephone: (312) 733-2800.

**Surgery**  
**ADVANCES IN SURGERY**  
 For: Surgeons. Lecture. May 9, 8:00 am—One week. Cook County Graduate School of Medicine, Chicago. Speaker: Robert J. Baker, M.D. (Coordinator). CME Credit: 40 hrs. AMA Cat. 1. Fee: \$200. Reg. Limit: 60. Sponsor, contact: Cook County Graduate School of Medicine, 707 S. Wood St., Chicago, 60612. Attn: Robert J. Baker, M.D., Dean. Telephone: (312) 733-2800.

**Recent CME Accreditations**  
**The ISMS Committee on Accreditation** has recently approved the CME programs of these hospitals:

**The Allergy & Clinical Immunology Society of Illinois**  
**Highland Park**  
**Augustana Hospital**  
**Chicago**  
**Christ Hospital**  
**Oak Lawn**  
**Garfield Park Community Hospital**  
**Chicago**  
**Holy Cross Hospital**  
**Chicago**  
**Northwest Community Hospital**  
**Arlington Heights**  
**Rock Island Franciscan Medical Center**  
**Rock Island**  
**South Chicago Community Hospital**  
**Chicago**  
**Southern Illinois Medical Association**  
**Belleville**



# Physician Recruitment Program

*In an effort to reduce the number of towns in Illinois needing physicians, the Physician Recruitment Program and the Doctor's Job Fair, are publishing synopses in the Journal.*

*Physicians who are seeking a place to practice or who know of any out-of-state physicians seeking an Illinois residence are asked to notify the Program.*

*Any areas wishing to be listed should contact: Mrs. E. Duffy, Physician Recruitment Program, ISMS, 55 E. Monroe, Suite 3510, Chicago, 60603.*

**ARCOLA:** F.P. or G.P. needed to join only physician in true rural community (2,300 population). Must be willing to do O.B. Ultimate plans for new 3-man clinic. Close to beautiful county hospital less than 10 years old. Robert N. Arrol, M.D., 126 S. Locust, Arcola, 61910. (217) 268-4444 or (217) 268-4404. (3)

**BLOOMINGTON:** Two active Internists seek Family Practitioners and Pediatricians to join evolving private group of primary-care practitioners. Group to consist of six physicians leasing office space in hospital-owned building. Organized within a Community Health Center setting. Contact: Michael Daniloff, Vice-President, Professional Services, Mennonite Hospital, 807 North Main Street, Bloomington, 61701 (309) 828-5241. (3)

**CAIRO:** Community Hospital with 20,000 population, staff of 1 Dentist, 1 Pediatrician, 1 OB/GYN, 2 General Surgeons, 1 Internist seeking ambitious General Practitioner for rural community. Recreation, (boating, fishing on lakes, rivers; golf, tennis), education, (public, private and parochial). Financial assistance in moving, office space, staff. Excellent potential. Contact: Harvey Petry, PADCO Community Hospital, Cairo, 62914. 618-734-2400. (5)

**CARTHAGE:** County Seat for Hancock County (Population 24,000). Need for Internist, Family Practice, and ER Physicians willing to conduct family practice. Memorial Hospital will guarantee first year income and provide office space. Four physicians and two surgeons at present. Contact: Harold A. Dietz, Administrator, Memorial Hospital, Carthage, 62321. 217-357-3131. (5)

**CHADWICK:** Rural area in northwestern corner of Illinois. Population 600. Strong farming community. Need general practitioner to set up solo practice. Office facilities available. Contact: Harold Frank, Box 38, Chadwick, 61014. (815) 684-5154 or 684-5147. (5)

**CHAMPAIGN:** General Internist, Pulmonary Medicine, Allergist, Oncologist/Hematologist, Rheumatologist, Family Practitioner, Dermatologist, Neurologist, Urologist and ENT opportunities in 31-man multispecialty, youth-oriented group. Guaranteed salary leading to early Associateship with future income based on individual productivity. Medium sized, Big-10 University community. Contact Mr. Arthur H. Perkins, Administrator, Christie Clinic, 104 West Clark Street, Champaign, 61820 (217) 351-1200. (3)

**CHESTER:** The Menard Correctional Center is presently searching for an Illinois Licensed physician,

GP or IM. Duties will include daily sick call, admission physicals and histories, daily rounds in institution medical unit and segregation unit. Salary dependent upon training and experience, and fringe benefits including malpractice insurance. Write: Cecil Patmon, Administrator, Medical Services, 160 North LaSalle, Room 425, Chicago 60601, or call collect 312-793-3216. (4)

**CHICAGO:** Staff Pathologist with a desire to develop new clinical laboratory procedures and work with an innovative specialized medical staff, needed to join our progressive university-affiliated Chicago hospital. Must be certified/eligible in clinical and anatomic pathology and interested in teaching. Excellent salary and benefit program. Write or call: Nancy Siegel, Staffing Specialist, Louis A. Weiss Memorial Hospital, 4646 North Marine Drive, Chicago, 60640, (312) 769-2162. (3)

**CHICAGO HEIGHTS:** 35 man multispecialty group needs Board certified or eligible family practitioner. Located in 100,000 sq. ft. building. Ancillary services available include X-ray, lab, cardiology stress testing, physical therapy, speech therapy, biofeedback, optical shop, pharmacy. Plans for further expansion with investment opportunities. Call Mr. H. Cloys, 333 Dixie Hwy., Chicago Heights, 60411. 312-756-7447. (5)

**DANVILLE:** Need Primary Care Physicians. Also Neurologist(s) and/or Neurosurgeon(s). Population 43,000. Service Area 180,000. Excellent schools, near university. Contact R. V. Livengood, Lakeview Medical Center, Danville, 61832 (217) 443-5201. (3).

**FORT MADISON, IOWA:** Openings for 2 FF/GP, OB, PED., Int. in growing industrial city of 16,000 serving 70,000 on Miss. River. Solo, partnership, clinic available. Substantial salary, other incentives. U. of Ia. near, Excellent living area, 125 bed accredited hospital. Contact: Donald A. Buckert, Sacred Heart Hospital, Fort Madison, Ia. 52627. 319-372-6530. (5)

**HARVEY:** General Practitioner or Family Practitioner opening available in our practice. Practice in the Chicago area and in the south suburb. Good pay and benefits. Interested parties please contact 333-1411 or P.O. Box 677, Harvey, 60426. (3).

**HERRIN:** Trade area of 40,000. Sportsman's paradise of Southern Illinois. 20 minutes from S.I.U. and Medical School. Internal Medicine and Family Practice needed now. Partnerships and solo available. Modern office facilities. Financial assistance. Contact: Larry Feil, Herrin Hospital, Herrin, 62948. (618) 942-4710. (5)

**HOMER:** Family Practitioner—Eleventh ranking county in U.S. gross farm income; 20 min. to large town with two hospitals; drawing area 12,000; house and office building offered; town may help with equipment. Contact: Douglas Driscoll, RR2, Homer, 61849. (217) 896-2434. (5)

**ILLIOPOLIS:** Needed Family Physician for small community. Surrounding area about 6,000 population. Industrial practice possible. Twenty miles from five major hospitals, on Interstate. Financial assistance available. Will work with you on office facilities. Contact: John Burke, R.R. 1, Illiopolis, 62539. Daytime—(217) 753-4861; night—(217) 486-6009—collect. (5)

**JACKSONVILLE:** Two-college town of 26,000 needs Primary Care Physicians. Excellent opportunity for F.P.s and Internists to join young, 37-member staff, expanding hospital, and progressive medical climate where patient care is the bottom line. Med. school 35 min's with good teaching opportunities. Contact: Larry Bear, Passavant Hospital, Jacksonville, 62651. (217) 245-9541. (5)

**LA SALLE-PERU:** Area population 35,000. Opportunities in hospital for family practice, internal medicine, pediatrics, OB-GYN. Twenty-five physicians at present with several over age 55. Two hours from Chicago. Office facilities. Financial assistance available. Numerous recreational facilities, good schools and housing. Contact: W. Schweickert, 925 West Street, Peru, 61354. (815) 223-3300. (5)

**LITCHFIELD:** Emergency Physician Opening—Join two full-time physicians staffing a Trauma Center in new hospital. Excellent salary, flexible scheduling to allow ample time for hobbies and leisure. Comfortable community of 8,000 with beautiful 1700 acre lake bordered by wooded homesites. Community interests include boating, fishing, hunting, farming, houses, golf, tennis, private flying and amateur theatre. One hour's drive to St. Louis or Springfield. Contact: Lee Johnson, M.D. or Jim Bohl at (217) 324-2191, St. Francis Hospital, Litchfield, 62056. (5)

**MENDOTA:** (City population 8000—service area 20,000). New medical clinic building next to hospital. Small town living with social and educational benefits of Chicago and other metropolitan areas close at hand. Financial assistance available. Busy practice available. Contact: E. E. Williams, Memorial Dr. & Rt. 51, Mendota, 61342. (815) 539-7461. (5)

**MORRIS:** Orthopedist and family practitioner urgently needed. Excellent opportunities for both in this rapidly growing rural community on Interstate 80 one hour from Chicago. Accredited 75-bed general hospital with new services and equipment planned. Service area 25,000-30,000. Contact: L. Wilhelm, M.D., P.O. Box 729, Morris, 60450. (815) 942-5474. (5)

**NEW ATHENS:** Population 2,200 (area population 17,000), 35 miles from St. Louis, Mo. Need one or two family physicians for new medical building. "Big city" attractions; best of shopping, recreation, and educational opportunities nearby. 1100 hospital beds within 20 minutes. Contact: Earl Becker, New Athens, 62264 or call collect (618) 475-2602. (5)

**ORLAND PARK:** Orland Park and far S.W. Chicago office, need general practice physicians, complete facilities both offices. New office bldg. completed Dec. 1, 1976. Contact: C. E. Cornelison, Adm., 10444 S. Kedzie, Chicago 60655, (312) 239-3000. (4)

**PEKIN:** Population 32,000. Hospital service area +50,000. Affiliated with Peoria School Medicine. 230-bed J.C.A.H. approved; well-equipped. Personal and capital financial assistance available. Ten miles to Peoria. Emergency services under contract. Opportunities for partnerships available. Contact: T. Larson or R. Tucker, M.D., Pekin Memorial Hospital, Pekin, 61554. (309) 347-1151. (5)

**ROCK ISLAND:** Excellent opportunity for family practitioners at new medical center physician's office building, rent free the first year. A substantial income guarantee and financial assistance are available. Contact: Thomas J. Lavery, Dir. Physician Recruitment, Rock Island Franciscan Hospital, 2701-17th Street, Rock Island, 61201. (309) 793-1000 (call collect). (5)

**RUSHVILLE:** Sixty miles west of Springfield. Progressive, growing community with 80 bed hospital serving population 12,000 to 15,000. Excellent schools, churches, shopping, recreation including a lake, golf course, pool, hunting and fishing. Office space with active physician, or private practice. Financial assistance. Contact: Charles Berry Jr., Administrator, Culbertson Hospital, Rushville, 62681. (217) 322-4321. (5)

**SANDWICH:** General Practice Physicians. Substantial annual guarantee, plus office facilities. 50 miles west of Chicago. Additional physicians are needed due to recent illness of one physician and death of another. Modern 92 bed hospital. Contact: President, Sandwich Community Hospital, 11 E. Pleasant St., Sandwich, 60548 or Phone 815-786-8484. (3)

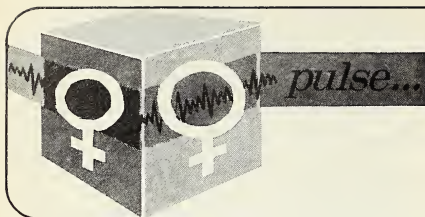
**SILVIS:** Primary Care Physicians (Family Practice, Internal Medicine, Pediatrics) wanted to locate in new medical building adjacent to suburban hospital in Illinois Quad-Cities. Guarantee offered. For additional details write or call Noel Lee, M.D., 4430-34th Avenue, Moline, 61265. (309) 797-5811. (5)

**SPRINGFIELD:** Currently seeking family practitioners, internists, and an otolaryngologist to establish practice in new Community Medical Plaza. We offer many benefits and assistance to help physicians get started. If interested, call collect: (217) 529-7151 or write to: Diana Smalley, 5230 South 6th Street-Frontage Road, Springfield, Illinois 62703. (5)

**STERLING/ROCK FALLS:** Population 28,000. Immediate need for Cardiologist (non-invasive) and E.N.T. Has progressive 167 bed JCAH hospital serving 80,000 people with unlimited growth potential, all in a pleasant community with excellent recreational facilities. Contact: Dallas K. Larson, Administrator, Community General Hospital, Sterling, 61081. (815) 625-0400. (5)

**WHITEHALL:** Area population 12,000. Urgent need for family practice or general practice. Excellent educational, cultural and recreational environment. Licensed 30 bed hospital. Office, housing, and financial assistance available. Excellent opportunity for man or woman. George A. Stahl, 407 No. Main, White Hall, 62092. (217) 374-2444. (5)





*pulse...* of the doctor's wife

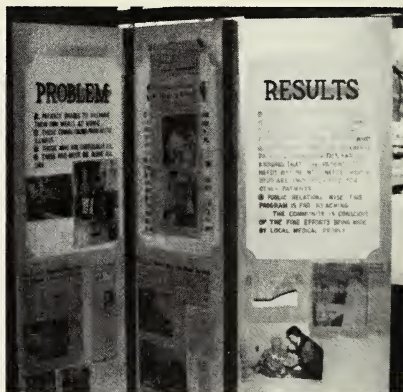
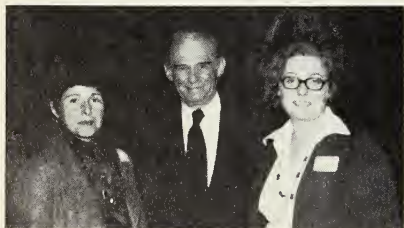
MRS. HAROLD KEEGAN, Editor

## MEALS—ON—WHEELS PROGRAM *A Viable Service Project*

Meals-on-wheels has been the community service project of the Chicago Medical Society's South Unit Auxiliary for about eight years. At the beginning the program was facilitated by the Auxiliary alone, but as the service expanded community volunteers were included. The meals are prepared at St. James Hospital and delivered to homebound persons in the community. Each recipient receives two meals a day, five days a week. At the present time, Mrs. J. R. Mossberg, chairman, and Mrs. John Koenig, co-chairman, have stated that 12 auxiliary volunteers are participating in the program. A luncheon is given each Spring for all volunteers.

### Impaired Physician Program

Dr. James W. West, a surgeon and assistant professor of psychiatry at Rush-Presbyterian-St. Luke's Medical Center in Chicago, and director of Alcoholism Services at Little Company of Mary Hospital in Evergreen Park, was the guest speaker for the Chicago Medical Society's South Unit Auxiliary December meeting. Dr. West's talk, "The Impaired Physician," considered the problems of physicians who become enmeshed in alcohol, drugs or mental illness.

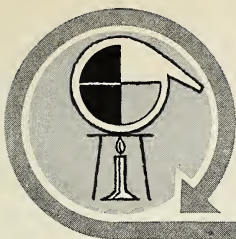


Meals-on-wheels display at the South Unit Auxiliary meeting.

### Special Note

The "How To" Guide Book revisions have been completed and the book will be put into circulation at the convention in April. The covers on the revised book were a gift of Merritt Printing Company of Chicago. Committee Co-Chairmen for the project were Mrs. Edward Szewczyk, Auxiliary Pres-Elect, and Mrs. Robert Hartman, Past President. Mrs. Robert Webb, 3rd Vice Pres., and Mrs. John Ovitz, Pres., served as members of the committee to revise the book.

(l to r) Mrs. John Ovitz, ISMS Aux. Pres., James W. West, M.D., and Mrs. Conrad Urban, Pres., South Unit Auxiliary.



# new pharmaceutical specialties

By PAUL DEHAEN

For detailed information regarding indications, dosage, contraindications and adverse reactions, refer to the manufacturer's package insert or brochure.

**New Single Drugs**—Drugs not previously known, including new salts.

**Duplicate Single Drugs**—Drugs marketed by more than one manufacturer.

**Combination Products**—Drugs consisting of two or more active ingredients.

**New Dosage Forms**—Of a previously introduced product.

**The following new drugs have been marketed:**

## NEW SINGLE DRUGS

**HIBICLENS** Antibacterial o.t.c.  
 Manufacturer: Stuart Pharmaceuticals  
 Nonproprietary Name: Chlorhexidine gluconate  
 Indications: Skin cleanser for surgical scrub  
 Applications: Wound cleaner  
 Supplied: As needed  
 Squeeze bottles, 4 and 8 oz.

**TICAR** Antibiotic Rx  
 Manufacturer: Beecham Laboratories  
 Nonproprietary Name: Ticarcillin Disodium  
 Indications: Primarily in susceptible Gram-negative infections  
 Contraindications: Allergy to Penicillin  
 Dosage: i.v. or i.m., not absorbed orally  
 Supplied: For details, see package insert  
 Vials, 1, 3 and 6 gm

## DUPLICATE SINGLE DRUGS

**ERGOSTAT** Analgesic—Migraine Therapy Rx  
 Manufacturer: Parke-Davis  
 Nonproprietary Name: Ergotamine Tartrate  
 Indications: Vascular headaches  
 Contraindications: See package insert  
 Dosage: Must not exceed three tablets in 24 hrs  
 Supplied: Tablets, 2 mg, sublingual

## NEW DOSAGE FORMS

**CYLERT, chewable tablets** Psychostimulant Rx  
 Manufacturer: Abbott Laboratories  
 Nonproprietary Name: Pemoline

Indications:

Caution:

Dosage:  
 Supplied:

**SORBITRATE SA**  
 Manufacturer:  
 Nonproprietary Name:  
 Indications:

Dosage:

Supplied:

Minimal brain dysfunction in children  
 Not recommended for children under 6 years  
 Single dose, each morning  
 Tablets, 37.5 mg

Coronary Vasodilator Rx  
 Stuart Pharmaceuticals  
 Isosorbide dinitrate  
 Acute anginal attacks  
 Prophylaxis in situations likely to provoke such attacks  
 That usual for isosorbide dinitrate  
 Tablets, sustained action, 40 mg

Deluxe nine story medical building, adjacent to Columbus Hospital and Lincoln Park, has suites available for immediate occupancy. Inside parking & full cleaning services. Free moving expenses & two months free rent available

**DOCTORS WANTED**  
 Suites, 350 to 6000 sq. ft. from \$8.50 per sq. ft.

## PARK PROFESSIONAL BUILDING

467 W. Deming Pl.  
 Chicago, Ill.  
 641-7000

McKey & Poague, Inc., Agents

# MARK YOUR CALENDAR

## ANNUAL MEETING OF THE ILLINOIS STATE MEDICAL SOCIETY

April 24 through 27, 1977

This year's annual meeting will be held in Chicago's newest hotel in the SKY, the HOLIDAY INN-MART PLAZA, Orleans Street at the Merchandise Mart. Shopping, banking and many other facilities are accessible in the hotel. Free parking is provided for guests. The Holiday Inn-Mart Plaza has restaurants, show lounges, and an indoor swimming pool. Plan to bring the family to the ISMS Annual Meeting, and enjoy the many "extras" of the most complete RESORT hotel in Chicago.

---

### Cut the Risk of a Malpractice Suit

Make an ISMS Action Call

312/782-1722

The ISMS ACTION CALL telephone information system gives you access to a constantly expanding library of taped messages which can help you minimize your chances of being sued. The library also contains tapes which outline what to do if you are sued and how to counter frivolous litigation.

You can consult the ISMS ACTION CALL tape library between 9 a.m. and 4:30 p.m., Monday through Friday. Dial (312) 782-1722 and ask for the tape by number.

#### No. PREVENTION/DEFENSE

1. Communication Can Prevent Litigation
2. Medical Records . . . A Key to Your Defense
3. Good Prescribing Habits Can Keep You Out of Court
4. Obtaining Patient Consent That Will Stand Up in Court
5. Parental Consent in Treatment of Minors . . . When It's Needed

#### SUITS/INSURANCE

6. What Happens When You're Sued
7. Dangers of Dropping Malpractice Coverage

#### COUNTER MOVES

8. Filing a Countersuit
9. Recovering Defense Costs Through Section 41
10. Initiating Disciplinary Action Against Attorneys

Blue Cross®  
Blue Shield®



# REPORT

## FOR *Illinois Physicians*

### Medical Assistants Workshops Begin in April

Blue Shield will conduct a series of workshops for medical assistants in several areas of the state beginning in April. A total of 40 morning and afternoon meetings have been arranged in central and downstate locations starting April 13 in Carbondale, Illinois and ending June 16 in Ottawa.

Medical assistants will be invited to attend either a morning or afternoon program. A complimentary luncheon is included for all participants. Registration for the morning program begins at 9:00 A.M. and the workshops are in session from 9:30 A.M. to 12:00 noon. The program is repeated at 1:00 P.M. following the noon luncheon, and adjournment is at 4:00 P.M.

The program will include a slide presentation showing the processing of a Blue Shield case and information on recent changes and additions to our Blue Shield contracts. Staff members of our Professional Relations Department will conduct the classes and special attention will be given to the newly employed medical assistant. Ample time will be provided for questions and answers.

Letters of invitation are being sent to physicians' offices in the areas where the workshops are sched-

uled, with a reservation form enclosed. For additional information on the meetings, please write or phone Mrs. Loretta O'Donnell, Blue Cross-Blue Shield Plan of Health Care Service Corporation, 233 North Michigan Avenue, Chicago, Illinois 60601. Telephone (312) 661-2964.

#### Schedule of Workshops

Wed., April 13	Ramada Inn	Carbondale
Thurs., April 14	Holiday Inn	Mt. Vernon
Wed., April 20	Augustine's	Belleville
Thurs., April 21	Holiday Inn	Edwardsville
Wed., April 27	Sheraton Inn	Mattoon
Thurs., April 28	Ramada Inn	Effingham
Wed., May 4	Ramada Inn	Danville
Thurs., May 5	Ramada Inn	Champaign
Wed., May 11	Ramada Inn	Quincy
Thurs., May 12	Holiday Inn	Macomb
Wed., May 18	Holiday Inn	Decatur
Thurs., May 19	Sheraton Inn	Springfield
Wed., May 25	Ramada Inn	Rockford
Thurs., May 26	Ramada Inn	Rockford
Wed., June 1	Ramada Inn	Bloomington
Thurs., June 2	Thurs., June 2	Peoria
Wed., June 8	Sheraton Inn	Rock Island
Thurs., June 9	Sheraton Inn	Galesburg
Wed., June 15	Holiday Inn	Kankakee
Thurs., June 16	Ramada Inn	Ottawa

---

### Notes on Contract Changes and Member Identification . . .

#### New Benefit Addition

The City of Chicago Retirees (Group 34022, 35623, 36058 and 49551) have a new benefit addition to their contract. The program coverage now provides outpatient diagnostic services limited to \$100 per calendar year under Blue Cross and \$100 per calendar year under Blue Shield, effective January 1, 1977. The basic contract for the groups is the Blue Cross 65 and Blue Shield 65 program, supplemental to Medicare.

#### Change in Membership Identification

Effective February 1, 1977 Mack Trucks, Inc. (Group 43801 and 43812) will require the use of the employee's Social Security number as the sub-

scriber number on all claims. The employee's Social Security number must also be used when services are furnished to dependents. In submitting a Physician's Service Report form, the proper sequence for member identification is: enter the Group Number 43801 or 43812 then the employee's Social Security number—for employee or dependent.

#### Blue Shield Benefits Cancelled

Northern Trust Bank Retirees (Group 80027) have cancelled the Blue Shield portion of the Blue Cross 65 and Blue Shield 65 contract, supplemental to Medicare, effective January 1, 1977. Physicians' services and charges are not covered by Blue Shield after that date.



## ASK BLUE SHIELD

### . . . ABOUT MEDICARE

#### Payment for Consulting Services

Payment for consulting services is made by Medicare when such services are determined to be reasonable and necessary to assist the attending or referring physician in assessing the patient's total medical condition.

A consultation is a request from the attending or primary physician for the advice and counsel of an accredited specialist. For payment of services by Medicare, a consulting physician must—on either the SSA-1490 form or his own billing statement—state the diagnosis and give the name and address of the referring or attending physician. A consultation must include a history, examination and written report filed with the patient's permanent medical record maintained by the attending physician.

#### Levels of Consultations

There are two levels of consultations furnished in hospital Medicare patients: a limited type and a comprehensive consultation.

A limited consultation is an examination and/or evaluation of a single organ system which does not require a comprehensive history.

A comprehensive consultation includes a history and examination; an extensive review of medical records; compilation and assessment of diagnostic material; and the preparation of a report for the attending physician.

#### Type Should be Indicated

When billing the Part B Medicare carrier for consultations always indicate which type of consultation was performed. If a comprehensive consultation was furnished, the description of services should include a comprehensive history and physical examination, with a written report for the patient's medical record. Without a clear description, the Medicare carrier generally assumes it was the limited type of consultation that was provided.

A referral is not considered a consultation. Referral implies the transfer of a patient to another physician for the management of a specific condition or procedure. In the case of a consultation, the patient most generally is returned to the primary physician. When it is decided that the patient would best be served by having the condition managed by the consulting physician, any continuous reimbursement to both physicians is evaluated on the special circumstances involved. The initial examination would be considered a consultation and is reimbursable if medically necessary and reasonable.

#### Completion of Items 10 and 11 on Form SSA-1490

A recent bulletin from the Department of Health, Education and Welfare discussed the completion of items 10 and 11 on the Medicare SSA-1490 form. Although prior to this time, Medicare has not placed emphasis on the completion of these items, physicians and suppliers are now instructed to complete the "amount paid" (item 10) and "any unpaid balance due" (item 11).

When a physician or supplier is accepting the assignment, item 10 must be completed with either a money amount or zero, whichever is applicable. It may be necessary in certain cases to split the Medicare payment between the physician and the patient. Such an example would be if the patient had already paid the physician more than the deductible and/or the 20% coinsurance. The Medicare Remittance Notice has a separate column which informs the physician of any such split payments.

"Any Unpaid Balance Due" (item 11), is the difference between the total charges (item 9) and Amount Paid (item 10). When a physician is accepting the assignment, this item must be completed before payment can be made by Medicare.

---

#### Changes in Laboratory Certifications

Fullerton-Harding Medical Laboratory formerly located at 2403 North Harding, Chicago, Ill. 60647 is now located at 3758 West Chicago Ave., and the name has been changed to P.R.N. Medical Laboratory. The Provider Number is 14-8295.

#### Laboratory Closings:

Prepaid Laboratory Service, Division of Ahead, Inc., 2010 South Arlington Heights Road, Arlington Heights, Ill. has ceased operations in the program. No payment can be made for services on or after August 18, 1976. Provider Number is 14-8285.

Chicago Medical Laboratory, 1518 North Ashland Ave., Chicago 60622 (Provider Number 14-8227) closed effective October 15, 1976. No payment can be made under the Medicare program for services furnished after that date.

Hilltop Medical Laboratory, 1321 West 87th Street, Chicago, Ill. (Provider Number 14-8249) has ceased its operations. No payment can be made under the health insurance program for services furnished on or after January 13, 1977.

# Medical Data-Plan®

**We're not offering you  
just a computerized  
billing system.  
We're offering you a way  
to plan the future  
of your practice.**

Medical Data-Plan is a computerized system for getting bills out, processing insurance forms, speeding up cash flow and improving collections.

It also gives you the information you need to plan the future of your practice . . . 3 years, 5 years, 10 years from now.

Based on a steady flow of accurate, timely computer reports, your business manager can make sound recommendations on personnel, equipment, materials, facilities and more. Medical Data-Plan can show you what your practice has been doing—and what it should be doing.

Clip this coupon to receive information or to arrange an appointment with a Data-Plan representative.



**Data-Plan**

Medical Data-Plan  
Box 7947, Madison, Wisconsin 53707

Name

Address

City

State  Zip

Check one or both boxes below:

☐ Please mail me more information about Medical Data-Plan.

☐ Please have a representative contact me.  
My phone number is:

(area code)

(number)

4-3

# Editorials



## Autogenous Conversation

Patient enters. During history taking it is identified that chief complaint is uncontrolled talking to himself. Not just occasionally, but frequently, often a full-fledged debate and argument.

Everyone does a small amount of talking to oneself, on occasion. Usually it's just "thinking out loud." When it becomes troublesome, remedial therapy is indicated. An abnormal condition must be treated so as to restore health to a whole body.

Similarly, medicine, the profession, is a whole body. However, when under duress this body often may seem to be afflicted with autoecholalia. When subjects such as NHI, PSRO, Discipline and Peer Review, HSA, Medicare, or other controversial items are broached, a cacophony of sound emanates.

Debate, discussion and decision making are important. This must be accomplished in an orderly, democratic fashion. A result will be unanimity of purpose, focused direction, and ultimate success.

However, if the whole body begins to be affected by actions bordering on automatic conversation, there can not be such success, since talking to oneself will not get the job done.

Medicine must speak out, and speak out forcefully, with a unanimous voice. Even though some may not agree, all must present a united front. This must be evidenced to the media, the legislators, and most importantly, to the public.

RO

The Illinois State Medical Society

Invites You On An

# Orient Adventure

Two weeks in exotic Japan and Hong Kong

Departing from Chicago on August 31, 1977

Returning September 14, 1977

Come with us for a relaxing, do-as-you-wish holiday in the Orient. See snow-capped Mt. Fuji and the glitter of the Tokyo's Ginza. Visit lush green Hakone and Nikko National Parks. See spectacular Hong Kong Harbor and colorful New Year's Eve. Shop for tailor-made clothes at bargain prices. Find tempting

buys in jade, pearls, silk, electronics and cameras. It all awaits you.

Orient Adventure includes: Direct chartered jet flights, deluxe hotels, American breakfasts, dinners at a selection of the finest restaurants, plus a generous 70 pound luggage allowance. A great trip. \$1538 a great value.



Send to: Illinois State Medical Society  
55 E. Monroe Street  
Suite 3510  
Chicago, Illinois 60603

Enclosed is my check for \$ \_\_\_\_\_ (\$100 per person)  
as deposit.

Name(s) \_\_\_\_\_

Home Address \_\_\_\_\_

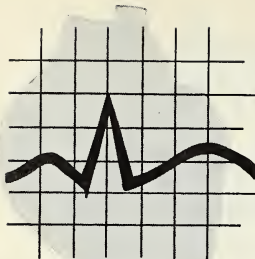
City \_\_\_\_\_

State \_\_\_\_\_

Zip \_\_\_\_\_

A Non-Regimented **INTRAV**, Deluxe Adventure

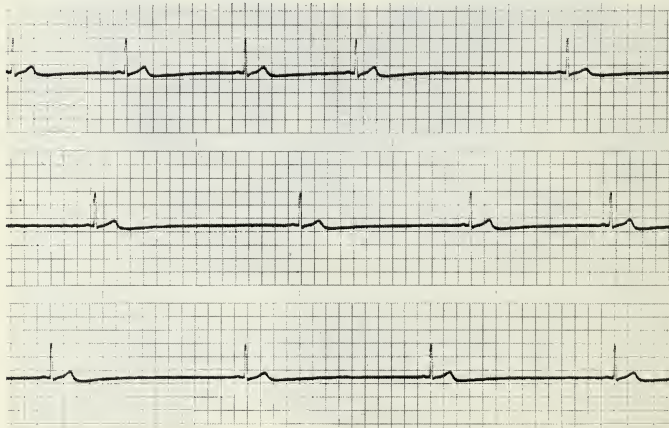




## ekg of the month

JOHN R. TOBIN, JR., M.S., M.D., RIMGAUDAS NEMICKAS, M.D.,  
PATRICK J. SCANLON, M.D., JOHN F. MORAN, M.S., M.D.,  
SARAH JOHNSON, M.D., and ROLF M. GUNNAR, M.S., M.D./  
Section of Cardiology, Department of Medicine,  
Loyola University Stritch School of Medicine

This patient is a 69-year-old man who had developed thrombophlebitis and a pulmonary embolus. He was treated with anticoagulants and did well. About two months later, while at home, he developed a sudden headache, vomited, and collapsed into unconsciousness. He was brought to the emergency service and neurosurgical consultation was obtained. Neurological examination demonstrated a comatose male with decerebrate responses on the left side. His pupils failed to react to light and the Babinski sign was present bilaterally. His prothrombin time was 35.4 seconds and the partial thromboplastin time was greater than 100 seconds. His coagulation defect was corrected and cerebral angiography was performed. Subsequently, a right frontal craniotomy was done and a large subdural and extensive right parietal intracerebral hematoma was found. Two days later an electroencephalogram showed electro-cerebral silence and this ECG rhythm strip was performed.



### Questions:

1. The ECG rhythm strip shows:
  - A. Severe sinus bradycardia.
  - B. Sinus arrhythmia.
  - C. Sinoatrial block.
  - D. Complete atrioventricular block.
  - E. All of the above.
2. In this patient, the following courses of action would be appropriate:
  - A. Temporary demand pacemaker.
  - B. Intravenous isoproterenol.
  - C. Intravenous ephedrine.
  - D. Digitalis.
  - E. No treatment.

(Answers on page 227)

# THERE ARE A LOT OF PEOPLE GETTING BETWEEN YOU AND YOUR PATIENT.

Medicine today is in the spotlight, subjected to all kinds of scrutiny. Your control over patient therapy is being monitored, judged and occasionally abrogated, sometimes by unknown third parties.

The worry is that in the wake of this focus, the relationship between you and your patient will be weakened, without offsetting benefits. Consider three examples:

**Drug substitution** In most states, pharmacy laws, regulations or professional custom stipulate that your non-generic prescriptions be filled with the precise products you prescribe. But in the last five years, a dozen or more State laws have been changed, permitting the pharmacist in most cases to select a product of the same generic drug to fill any prescription.

Ironically, this dilution of physician control has taken place against a background of growing evidence that purportedly equivalent drug products may be inequivalent, since neither present drug standards nor their enforcement are optimal. In fact, the FDA itself says it has not enforced the same standards for hundreds of "follow-on" products that it had applied to the original NDA approvals. Thus physician control over patient therapy is being eroded with a risk that patients may be exposed to drugs of uncertain quality.

The major advertised claim for substitution is reduced prescription prices for consumers. Yet no documentation of any significant savings has been produced.

**MAC** Maximum Allowable Cost, MAC for short, is a Federal regulation designed to cut the Government's drug bill by setting price ceilings for drugs dispensed to Medicare and Medicaid patients. Unless the prescriber certifies on the prescription that a particular product is medically necessary, the Government intends to pay only for the cost of the lowest-priced, purportedly-equivalent,

generally-available product. The effect of the program may be that elderly and indigent patients will be restricted to products which someone in Washington believes are priced right. Practicing doctors will have little to say about administration of the program, since Government will have absolute authority to make its choices stick.

**The drug lag** The future of drug and device research depends upon a scientific and regulatory environment that encourages therapeutic innovations. The American pharmaceutical industry annually is spending more than \$1 billion of its own funds and evaluating more than 1,200 investigational compounds in clinical research. Disease targets include cancer, atherosclerosis, viruses and central nervous system disorders, among others. But there is a major barrier to the flow of new drugs to your patients: The cost of the research is more than ten times what it was, per product, in 1962; and whereas governmental clearance of new drug applications took six months then, it commonly consumes two years now.

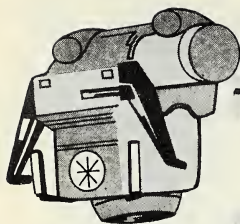
The FDA needs adequate time, of course, to consider data. But it is equally clear that the present approval process contributes to needless delay of needed therapy. That's why the increased efficiency of the drug approval process is vital to all our futures.

If these issues concern you, we suggest that you make your voice heard—among your colleagues and your representatives in State legislatures and in Washington.

It could make a difference in your practice tomorrow.



Pharmaceutical Manufacturers Association  
1155 Fifteenth Street, N.W., Washington, D.C. 20005



## the view box

LEON LOVE, M.D./CHAIRMAN/DEPARTMENT OF RADIOLOGY  
LOYOLA UNIVERSITY STRITCH SCHOOL OF MEDICINE

This patient is a 25-year-old female with chest X-rays which were taken three years apart. One of the films is abnormal. Can you tell which one it is and what is the patient's disease?

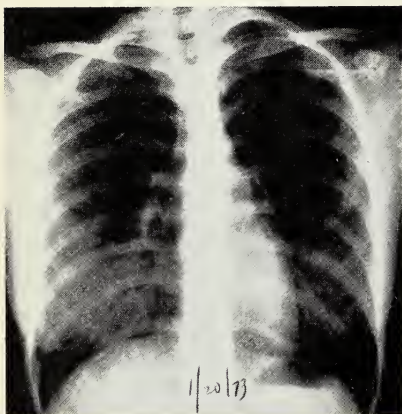


Figure 1 (1/20/73)

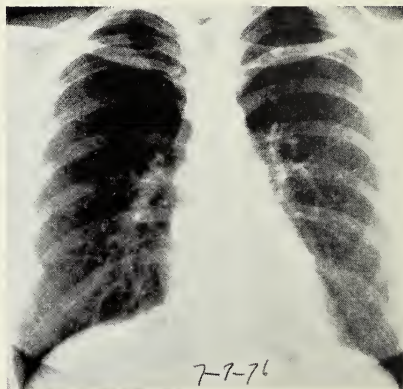


Figure 2 (7/7/76)

***What's Your Diagnosis?***

*(Answer on page 189)*

100 mg

250 mg

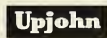
500 mg



# **Tolinase<sup>®</sup>**

**tolazamide, Upjohn**

Please contact your Upjohn representative for additional product information.



7-5675-6  
© 1977 THE UPJOHN COMPANY



## OBITUARIES

\*Baldree, Charles E., Belleville, died April 30th at the age of 71. Doctor Baldree was a 1928 graduate of the University of Tennessee.

\*Beckmann, William E., Park Ridge, died January 9th at the age of 78. Doctor Beckmann was a 1925 graduate of Fordham, N.Y.

\*Beneshohn, Solomon J., Chicago, died January 25th at the age of 68. Doctor Beneshohn was a 1932 graduate of the University of Illinois.

\*DeYoung, Vernon R., Chicago, died January 24th at the age of 73. Doctor DeYoung was a 1932 graduate of the University of Illinois.

\*Fitz, Casimir E., Chicago, died February 3rd at the age of 57. Doctor Fitz was a 1944 graduate of the Stritch School of Medicine.

\*Friedman, David, Granite City, died December 30th at the age of 65. Doctor Friedman was a 1934 graduate of Washington University.

\*Grant, Walter S., Chicago, died January 13th at the age of 83. Doctor Grant was a 1921 graduate of Northwestern University.

\*Kaplan, Morris A., Chicago, died January 6th at the age of 69. Doctor Kaplan was a 1932 graduate of the University of Illinois.

\*Leffman, Alfred A., Mattoon, died January 2nd at the age of 69. Doctor Leffman was a 1932 medical school graduate from Germany.

\*Leyers, Rudolph P., Justice, died January 1st at the age of 67. Doctor Leyers was a 1934 graduate of Rush Medical College.

\*Loring, Arthur A., Chicago, died January 19th at the age of 85. Doctor Loring was a 1927 graduate of Chicago Medical School.

\*Meadows, William A., Lockport, died January 18th at the age of 72. Doctor Meadows was a 1953 graduate of the University of Alberta, Canada.

\*Myers, James D., Peoria, died January 31st at the age of 49. Doctor Myers was a 1954 graduate of the University of Illinois.

\*Olechowski, Henry C., Elmwood Park, died January 29th at the age of 67. Doctor Olechowski was a 1936 graduate of the Stritch School of Medicine.

\*Overstreet, Robert J., Chicago, died February 9th at the age of 50. Doctor Overstreet was a 1953 graduate of the University of Oklahoma College of Medicine.

\*Rambach, Walter A., Chicago, died January 23rd at the age of 56. Doctor Rambach was a 1948 graduate of Northwestern University.

\*Sanders, Robert Z., Decatur, died October 6th at the age of 89. Doctor Sanders was a 1911 graduate of the University of Illinois.

\*Schneider, Philip F., Arizona, formerly of Evanston, died December 1st, at the age of 82. Doctor Schneider was a 1918 graduate of Northwestern Medical School.

\*Sihler, Charles H., Litchfield, died September 24th at the age of 81. Doctor Sihler was a 1920 graduate of McGill University at Montreal Canada.

\*Sneor, Yako, Chicago, died October 3rd at the age of 51. Doctor Sneor was a 1950 graduate of the University of Istanbul.

\*Staack, H. F., Jr., Chicago, died January 26th at the age of 54. Doctor Staack was a 1946 graduate of the University of Illinois.

\*Sparrison, Charles G., Chicago, died January 25th at the age of 72. Doctor Sparrison was a 1929 graduate of the Stritch School of Medicine.

\*Wachtel, Hans, Chicago, died February 2nd at the age of 67. Doctor Wachtel was a 1933 graduate of the University of Ludwig, Germany.

\*Wagner, Jack, Chicago, died January 6th at the age of 67. Doctor Wagner was a 1936 graduate of the University of Illinois, Chicago.

\*White, Charles O., Belleville, died May 7th at the age of 61. Doctor White was a 1939 graduate of Washington University.

\*Wichowski, Walter A., Chicago, died January 20th at the age of 58. Doctor Wichowski was a 1944 graduate of Northwestern University.

\*Indicates ISMS member.

\*Indicates member of the ISMS Fifty Year Club.

### COOK COUNTY

#### Graduate School of Medicine

#### CONTINUING EDUCATION COURSES

##### STARTING DATES - 1977

SPECIALTY REVIEW SURGERY, PART II, March 14

NEUROLOGY, PART I, BASIC, March 14

BASIC INTERNAL MEDICINE, One Week, March 14

NEUROPATHOLOGY, One Week, March 21

DIAGNOSIS & MANAGEMENT OF PROBLEMS IN GYNECOLOGY, March 21

BASIC EKG, One Week, March 21

EKG FOR ANESTHESIOLOGISTS, One Week, March 21

ADVANCED EKG, Two and a half days, March 28

BASIC REVIEW PSYCHIATRY, One Week, March 28

SURGERY OF THE G. I. TRACT, One Week, April 11

SPECIALTY REVIEW PEDIATRICS, One Week, April 11

DIAGNOSTIC RADIOLOGY, One Week, April 11

SPECIALTY REVIEW UROLOGY, One Week, April 18

REVIEW IN MEDICAL GENETICS, Three days, April 18

BASIC SEMINAR IN ECHOCARDIOGRAPHY, Three days, April 20

STATE & NAT'L. BO. REVIEW, BASIC, April 24, CLINICAL, May 2

FAMILY PRACTICE REVIEW, One Week, April 25

*Information concerning numerous other continuation courses available upon request.*

#### Address:

REGISTRAR, 707 South Wood Street,  
Chicago, Ill. 60612

# WHY YOUR EMPLOYEE BENEFIT PLAN MAY NEED A CHECKUP

## 3 GOOD REASONS TO CONSULT THE PROFESSIONALS AT CITIZENSBANK.

**1.** The Employee Retirement Income Security Act of 1974. Whether you already have a pension or profit-sharing plan or are thinking of starting one, you should know about recently enacted federal legislation that brings significant changes to all employee benefit plans.

With CitizensBank in Park Ridge, you can be sure your plan will stay healthy. We're up to date with all the new requirements, so you know your plan will conform to government standards.

**2.** Investment know-how. If your benefit plan investments should be doing better, you may want to find out how our experts make the investment decisions that have attracted so many employee benefit plans to CitizensBank.

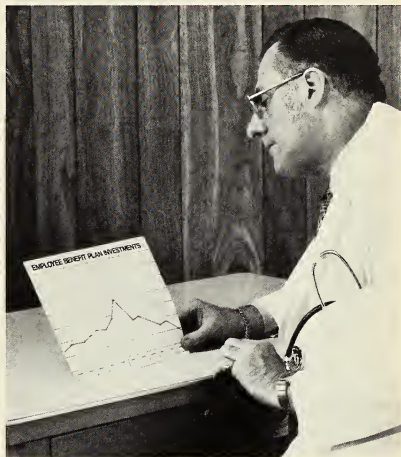
**3.** Our professional staff can give your retirement plan fund the same expert, prudent money management that has helped CitizensBank become the largest bank in Illinois outside Chicago's Loop.

If you are thinking of beginning a pension or profit-sharing plan or would like to discuss your existing plan, call Paul Pavelski in our Trust Financial Planning Division at 825-7000. Or, to discuss a plan or receive timely information on employee benefit plans, just complete and mail the coupon. There's no obligation.

## CitizensBank-Trust



Citizens Bank & Trust Company  
One Northwest Highway • Park Ridge, Illinois 60068  
312-825-7000 • 631-4270  
Member FDIC - FRS



### FREE PLAN INFORMATION

- ☐ Yes, I would like to receive information on pension and profit-sharing plans. Please send me your new brochure.
- ☐ Yes, I would like to discuss my existing plan.
- ☐ Yes, I would like to discuss beginning a plan.

Name \_\_\_\_\_

Phone \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

**Citizens Bank & Trust Company,**  
One Northwest Highway, Dept. IM-37  
Park Ridge, Illinois 60068

## ***Clinics for Crippled Children***

### ***Listed for April***

Thirty-four clinics for Illinois physically handicapped children have been scheduled for April by the University of Illinois, Division of Services for Crippled Children. The Division will count 25 general clinics providing diagnostic orthopedic, pediatric, speech and hearing examination, along with medical social and nursing services. There will be eight special clinics for children with cardiac conditions and one for children with cerebral palsy. Any private physician may refer to or bring to a convenient clinic any child or children for whom he may want examination or consultative services.

- April 1 Division Cardiac, U. of I. at the Medical Center
- April 5 Belleville, St. Elizabeth's Hospital
- April 5 Quincy, Blessing Hospital
- April 5 Metropolis, Massac Memorial Hospital
- April 6 Cairo, Public Health Department
- April 6 Hinsdale, Hinsdale Hospital
- April 7 Sterling, Community General Hospital
- April 7 Springfield, St. John's Hospital
- April 7 Effingham, St. Anthony Memorial Hospital
- April 7 Lake County Cardiac, Victory Memorial Hospital
- April 11 Peoria Cardiac, St. Francis Hospital
- April 12 E. St. Louis, Christian Welfare Hospital
- April 12 Peoria, St. Francis Hospital
- April 12 Rock Island, Moline Public Hospital
- April 13 Springfield Pediatric Neurology, St. John's Hospital
- April 13 Champaign-Urbana, McKinley Hospital
- April 13 Chicago Heights General, St. James Hospital
- April 13 Joliet, St. Joseph's Hospital
- April 13 Rockford, St. Anthony's Hospital
- April 14 Kankakee, St. Mary's Hospital
- April 15 Chicago Heights Cardiac, St. James Hospital
- April 18 Maywood, Loyola Medical Center
- April 19 Decatur, Decatur Memorial Hospital
- April 21 Rockford, Rockford Memorial Hospital
- April 21 Bloomington, Mennonite Hospital
- April 21 Elmhurst Cardiac, Memorial Hospital of DuPage County
- April 22 Chicago Heights Cardiac, St. James Hospital
- April 22 Evanston, St. Francis Hospital
- April 25 Peoria Cardiac, St. Francis Hospital
- April 26 Peoria, St. Francis Hospital
- April 26 Park Ridge Cardiac, Lutheran General Hospital
- April 27 Centralia, St. Mary's Hospital
- April 27 Aurora, St. Joseph Mercy Hospital
- April 28 Litchfield, St. Francis Hospital

The Division of Services for Crippled Children is the official state agency established to provide medical, surgical, corrective and other services and facilities for diagnosis hospitalization and after-care for children with crippling conditions or who are suffering from conditions that may lead to crippling. In carrying on its program, the Division works cooperatively with local medical societies, hospitals, the Illinois Children's Hospital-School, civic and fraternal clubs, visiting nurse association, local social and welfare agencies, local chapters of the National Foundation and other interested groups. In all cases the work of the Division is intended to extend and supplement, not supplant activities of other agencies, either public or private, state or local, carried on in behalf of crippled children.

## **DIRECTOR OF MEDICAL EDUCATION**

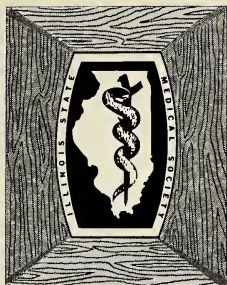
The Ravenswood Hospital Medical Center on Chicago's near north side, seeks a Doctor of Medicine for the long-established position of Director of Medical Education. The individual for this position shall have demonstrated professional and administrative abilities; shall possess a working knowledge of educational techniques; and shall have achieved eminence in the field as evidenced by faculty status in a medical school or teaching hospital.

DME shall be administratively responsible for maintaining the Medical Center's affiliation with the University of Illinois College of Medicine for undergraduate medical students, the Hospital's graduate residency program for 34 positions, and for the continuing medical education program.

Upon completion of the present buildings now under construction, the Medical Center will have 468 beds to provide comprehensive health care to the community, plus over 25,000 sq. ft. of educational facilities.

Compensation and benefits will be comparable to similar top positions. Apply: H. H. Hetz, M.D. Chairman—Search Committee of Medical Education, Ravenswood Hospital Medical Center, 4550 N. Winchester, Chicago, IL 60640. An Equal Opportunity Employer





# I M J

Illinois Medical Journal

Vol. 151, No. 3, March, 1977

## Group B Beta Hemolytic Streptococcal Infection in Neonates

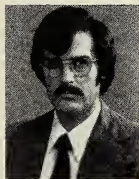
By RONALD TURNER, M.D./COLUMBUS, OHIO  
AND RONALD E. KEENEY, M.D./SPRINGFIELD

*Group B beta hemolytic streptococcal infection (GB-BHS) in the newborn has taken on near-epidemic proportions in many parts of the United States. Even though data on the subject have proliferated in recent medical literature and at scientific meetings, confusion persists for practical management. This paper offers an overview and summary of the current literature and recommends a plan of action based on recent bacteriologic, immunologic and epidemiologic findings.*

Bacterial infection in the neonatal period has only incompletely succumbed to the "miracle" of antibiotic therapy.<sup>1</sup> As antimicrobial drugs are developed to combat the prevalent microorgan-

ism, another organism tends to predominate. Since 1940, the gram-negative enteric bacteria have accounted for the majority of cases of neonatal sepsis.<sup>2</sup> While the incidence of gram-negative infections has remained unchanged, certain gram-positive pathogens have increased and decreased in importance at approximately 10 year intervals.<sup>3</sup> Most recently the Group B beta hemolytic Streptococcus (GB-BHS) has become increasingly important as a cause of infection and death in the neonate.<sup>1</sup> As early as 1963, some hospitals were reporting that GB-BHS was the predominant cause of sepsis among neonates.<sup>4</sup> Since that time there has been an increasing incidence of this organism as a cause of neonatal sepsis and the search for a way to conquer this infection goes on.

**RONALD E. KEENEY, M.D.**, is an assistant professor at the Southern Illinois University School of Medicine in Springfield. Dr. Keeney is also on the pediatric staffs at St. John's Hospital and Memorial Medical Center in Springfield. Dr. Keeney is widely published, and his work includes a variety of articles dealing with infections and the problems of child abuse. He is a fellow of the American Academy of Pediatrics.



**RONALD TURNER, M.D.**, is a first year pediatric resident affiliated with the Ohio State University Hospitals in Columbus, Ohio. Dr. Turner is a graduate of the Southern Illinois University Medical School in Springfield.

### Incidence

GB-BHS has accounted for 25-37% of all cases of neonatal sepsis<sup>2,4</sup> and is now the single most



frequent cause in some centers.<sup>1,4</sup> Franciosi, et al.<sup>2</sup> found the incidence of infection and death due to GB-BHS to be 3.2 and 1/1000 live births respectively. Baker and Barrett<sup>5</sup> found the incidence of infection to be 2.9/1000 live births. The incidence of GB-BHS infection in the newborn infant is closely related to the incidence of colonization in third trimester women and in hospital personnel. Studies in these two groups show that 4.6-25.4% of parturient women and 11.1-32.2% of nursery personnel have positive cultures for GB-BHS.<sup>25</sup> Hood and associates<sup>6</sup> report that of the mothers with positive vaginal cultures (5% in their study) 37% had abortion, perinatal death or serious illness of the infant. Subsequent studies, however, have shown a rate of infection of about 1% in infants born to mothers with positive cultures.<sup>2,5</sup> Also of interest is the fact that GB-BHS has an unexpectedly high incidence in whites and in females.<sup>7,8,9</sup> More recently Baker, et al.<sup>10</sup> have shown that babies at risk of early onset infection are those born to colonized mothers without circulating antibodies against GB-BHS.

### Clinical Manifestations

GB-BHS infection has several different presentations; the two most important referred to as early-onset and late-onset types.

The early-onset type of GB-BHS infection is characterized by evidence of infection before the tenth day post-partum. The route of infection most often is probably ascension from the mother's genital tract or colonization while the infant is passing through the birth canal. This proposed route of infection is supported by reports that the serotypes of the maternal organisms tend to correspond with the serotypes of the organisms colonizing the infant.<sup>2,11</sup> There is variation, however, over which serotype is the predominant cause of early-onset disease in different series. Franciosi, et al.<sup>2</sup> found a predominance of serotypes I<sub>a</sub>, I<sub>b</sub> and I<sub>c</sub> in both mothers and infants. Baker and Barrett,<sup>11</sup> on the other hand, report serotype III as the primary cause of early-onset disease. The role of obstetric complications such as premature labor, premature rupture of membranes (more than 24 hours), and maternal fever in the perinatal period is incompletely resolved, but Baker and Barrett<sup>9</sup> have demonstrated a 92% correlation of the above obstetric factors with early-onset meningitis. Other studies<sup>2,8,12</sup> have failed to duplicate this correlation.

Early-onset infection caused by GB-BHS is

usually manifested by the sudden unexplained onset of apnea and/or seizures with lethargy within the first 24 hours of life.<sup>7,9,12,13</sup> Early-onset disease occurs in preterm, low-birth-weight, as well as in full-term, normal sized babies and may be impossible to differentiate from idiopathic respiratory distress syndrome (RDS) of the newborn. Any full-term infant with clinical RDS must be suspected as having GB-BHS sepsis.<sup>14</sup> Ablow and associates<sup>13</sup> have suggested ways in which this differentiation can be made: the presence of low peak inspiratory pressure on the volume-cycled ventilator and the presence of gram-positive cocci in the gastric aspirate are highly suggestive of GB-BHS infection. Babies with infection had a mean peak inspiratory pressure of 36.5 cm of water compared to a mean of 63.9 cm of water in babies with RDS. The radiologic findings in early-onset disease are not specific and cannot be relied upon for differentiation from RDS.<sup>7,13</sup>

### Late-Onset Infection

Late-onset infection is the designation given to those infections which are first manifested after the tenth day post-partum. The origin of late-onset disease is still not completely elucidated. Franciosi and associates<sup>2</sup> found that a high percentage of late-onset infections were caused by serotype III of GB-BHS. At the same time they reported many mothers to be colonized with serotype I compared to non-pregnant women (including nursery personnel), the majority of whom were colonized with serotype III. On the basis of these data it was postulated that late-onset infections were transmitted to the infant post-partum. Baker and Barrett,<sup>5</sup> while agreeing with the finding of serotype III in the infants, reported that pregnant women in the third trimester were as likely to be colonized with serotype III as were non-pregnant women. This finding, though it does not disprove the mechanism postulated by Franciosi, et al., makes maternal-fetal transmission a possibility.<sup>9</sup> The infant may be colonized at birth and harbor the bacteria for several weeks before showing signs of disease—perhaps triggered by a viral infection.<sup>7</sup>

The manifestations of late-onset disease are usually those classically associated with meningitis, including fever and full anterior fontanel.<sup>2,7,9</sup> The high incidence of meningitis in late-onset infection is probably due to the fact that it is most commonly caused by type III GB-BHS<sup>2,11</sup> which seems to have a propensity to

cause meningitis.<sup>5,11</sup> It has been suggested that this peculiar meningeal invasive property may be related to biochemical characteristics of the capsule of GB-BHS type III<sup>11</sup> as is the case with the acidic polysaccharide antigen present in group B meningococci.<sup>15</sup>

### Other Manifestations

The early and late-onset types of disease have dominated the literature on GB-BHS infection in recent years. Reports are beginning to appear of other presentations of GB-BHS infection.<sup>1,16,17</sup> The incidence of these unusual presentations has been reported to be as high as 17% of all GB-BHS disease.<sup>1</sup>

Seven cases of osteomyelitis/septic arthritis have been reported in the literature.<sup>1,16</sup> These all presented later than ten days post-partum and three presented with pseudoparalysis as the only symptom, with no fever or leukocytosis. The four patients for whom follow-up was available had an uncomplicated recovery. Other manifestations which occurred less commonly were asymptomatic bacteremia facial cellulitis, empyema, conjunctivitis and ethmoiditis;<sup>1</sup> all of these presented in the first ten days of life except the ethmoiditis. All recovered except the patient with facial cellulitis and the patient with empyema. Another manifestation of GB-BHS infection is congenital impetigo. A newborn infant was reported by Belgaumkar<sup>17</sup> who at birth had widespread, superficial ulcers which crusted over to assume the characteristic appearance of impetigo of older children. There was some lymphadenopathy but no other evidence of systemic disease and the infant made an uneventful recovery.

### Bacteriology

The increasing awareness of the importance of

GB-BHS disease has led to a search for reliable means by which laboratory identification of the organism can be made. Serologic testing as described by Lancefield<sup>18</sup> in 1933, is the only accurate way in which group B organisms can be positively identified. Since serotyping is complex and not universally available, attention has turned to presumptive tests for group B identification. The data of Facklaum, et al.<sup>19</sup> indicate that hemolysis, bacitracin disc sensitivity, sodium hippurate hydrolysis, and the bile-esculin test can be used to provide an accurate indication of the presence of Lancefield group B. They report that 99.5% of group A streptococci were sensitive to bacitracin as compared to 6% of group B and 0% of group D organisms. On the other hand, 99.6% of group B organisms hydrolyzed sodium hippurate compared to 0% of group A and 6.9% of group D organisms. Finally, 99.6% of group D had a positive bile-esculin test compared to 0% of groups A and B. More recently, caution has been expressed with regard to total reliance on beta hemolysis for group typing since some Lancefield group B Streptococci have been demonstrated to lack beta hemolysis.<sup>20</sup>

Another method for presumptive identification of GB-BHS is based on colony morphology. Braunstein, et al.,<sup>21</sup> described the colony characteristics as shown in Table 1. Obviously, the differentiation of groups B and D is not possible on the basis of colony morphology alone. It has been suggested<sup>7</sup> that sensitivity to methicillin could be used to make the differentiation since group B is 100% susceptible whereas group D is resistant. However, Duma, et al.,<sup>22</sup> report that 29% of group D organisms are susceptible to methicillin making the differentiation on this basis only partially reliable. For this reason one of the biochemical tests mentioned above would be a better means of identification.

TABLE 1

Group Related Streptococcal Colony Morphology on Sheep's Blood Agar at 24 Hours			
Characteristic	Group A	Group B	Group D
Type of hemolysis	almost always beta	almost always beta	occasionally beta
Zone of hemolysis	large, clear	hazy, smaller	hazy, smaller
Size of colony	less than 1 mm.	greater than 2 mm.	1-2 mm.
Transillumination	transparent	translucent, central opacity	central opacity, peripheral translucence
Colony Morphology	central elevation, firm	gray, mucoid, soft	watery

A third presumptive test is the CAMP reaction.<sup>23</sup> This test is based on the enhancement of hemolysis by GB-BHS in the presence of beta hemolytic staphylococci. This enhancement does not occur with any other group of streptococci.

### Treatment

The treatment of GB-BHS infections is, as would be expected, similar to that for other beta-hemolytic streptococcal infections. Penicillin G has been the drug most active against GB-BHS, followed by erythromycin and ampicillin.<sup>4</sup> Some strains have been reported resistant to both erythromycin and penicillin G.<sup>4,24</sup> The dosage of the antimicrobials as well as the route and duration of therapy is the same as for other meningitides (penicillin G, 300,000 units/kg/day 4 in six divided doses). It has been shown that aminoglycosides and penicillin work synergistically against enterococci<sup>25</sup> on the basis that inhibition of cell wall synthesis by penicillin results in increased permeability and enhancement of egress of the aminoglycosides into the cytoplasm where it attacks the ribosome. A study is presently under way at Southern Illinois University School of Medicine research laboratories to evaluate synergy of antibiotic combinations against GB-BHS.

The mortality of GB-BHS infections has remained virtually unchanged during the last few years.<sup>1</sup> The mortality of early-onset infection has been reported as 58-71%.<sup>2</sup> Three different papers report the mortality of late-onset infection as 14%, 18% and 45% respectively.<sup>2,8,9</sup> Surprisingly, the reported incidence of neurologic sequelae of late-onset infection is low, less than 5%.<sup>9</sup> The prognosis for infections which present in an unusual manner is apparently better than for the classic presentations. Mortality in the reported cases is about 12.5%.<sup>1,16,17</sup>

### Comment

The study of GB-BHS infection in neonates has revealed that it includes at least two syndromes with different symptoms and mortality, and perhaps different routes of infection. In light of these findings, it should not be surprising that control of these infections requires differing approaches. The late-onset infection seems to have clinical findings and response to treatment similar to other meningitides. In contrast, the early-onset disease is fulminant and, even when the diagnosis is made pre-mortem, antibiotic therapy frequently offers little benefit.<sup>12</sup> With these factors in mind, much discussion has been directed

toward methods of prophylaxis against this type of infection.<sup>2,5,13,26</sup> Baker and Barrett<sup>5</sup> point out that treatment of all parturient women who are colonized with GB-BHS is probably impractical since only about 1% of infants born to these mothers will develop clinical infection. Prolonged therapy of these mothers may be necessary since it is impossible to predict when delivery will occur. Hall et al.<sup>27</sup> point out that treatment of mothers which is not continued up to the time of delivery often is followed by recolonization prior to delivery. In one series it was impossible in at least one instance to eradicate the vaginal carrier state in spite of prolonged therapy with multiple antibiotics.<sup>19</sup> On the other hand, the efficacy of prophylactic administration of penicillin G to infants at risk is suggested by a series of 120,000 deliveries in which all newborn infants were given 50,000 units of aqueous penicillin G IM in the delivery room to prevent neonatal gonococcal ophthalmia.<sup>28</sup> Using the incidence rates described by Franciosi,<sup>2</sup> one would expect 180 septic babies and 120 deaths among 120,000 deliveries. In the reported series, however, there were no identified clinical infections or deaths due to GB-BHS.<sup>26</sup> Though this series is retrospective and uncontrolled, data of this sort indicate that this method may deserve further controlled study as a potential prevention for GB-BHS neonatal disease.

The most practical recommendation may be to obtain third trimester vaginal cultures and serologic studies in mothers, instituting prophylactic treatment of babies born to GB-BHS colonized mothers who lack circulating antibodies against GB-BHS. This approach to prevention also demands controlled clinical evaluation.

At the very least, enough data are currently available to indicate the wisdom of obtaining vaginal cultures from third trimester and intrapartum mothers to provide early, useful etiologic data to the physician who must select therapy for the infant who begins to manifest evidence of neonatal sepsis or RDS.

Should an epidemic of late-onset GB-BHS neonatal sepsis be identified in a given nursery, oral, vaginal and rectal cultures of nursery personnel may be needed to identify the source of infection and allow control of the epidemic. ◀

### References and Reprints

A complete list of references for "Group B Beta Hemolytic Streptococcal Infection in Neonates" may be obtained by writing the *Illinois Medical Journal*, 55 E. Monroe Street, Suite 3510, Chicago, 60603.

Requests for reprints of this article should be addressed to Dr. Ronald E. Keeney, SIU School of Medicine, P.O. Box 3926, Springfield, 62708.



# Propanolol in Attempted Suicide

By ANTONIO BOBA, M.D., AND KENNETH A. PEART, M.D./MT. VERNON

*Given the intent to self-destruct, real or demonstrative, patients will resort to whatever drug or agency that is readily available. As propanolol (INDERAL®) becomes more readily available for therapeutic purposes then the likelihood that it should be used for the purpose of self-destruct will also and unavoidably increase. One such instance was observed recently and it is reported.*

*This article was prepared in co-operation with the Southern Illinois Clinic Ltd. and the Intensive Care Unit of the Good Samaritan Hospital, Mount Vernon, IL.*

A 56-year-old woman was brought to the Emergency Room about three hours after ingestion of 250 ml of an alcoholic beverage (40.0% by volume) and no less than 40 tablets of propanolol (10 mgm each) following a family spat.

At the time of admission the patient was alert and oriented; she spoke haltingly but coherently. The pulse rate

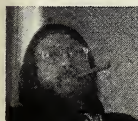
was 80 per minute and there was no peripheral pulse deficit. Sphygmomanometric determination of the blood pressure was not possible. The color of all exposed mucosae was good and ventilatory activity was normal by percussion and auscultation. The abdomen was soft and the bowel sounds were present. An electrocardiogram was obtained and it was interpreted as "sinus rhythm, with occasional sinus arrhythmia and some scattered premature contractions. Old anteroseptal infarction, T wave abnormalities, ST segment abnormalities. Subendocardial ischemia."

Upon questioning, the patient confirmed the ingestion of alcohol and propanolol. She also supplied a complete medical history, of which the following appeared to be pertinent. She had suffered a severe anginal episode at age 24 and a well documented myocardial infarction at age 44. Following the latter illness she had suffered from non-specific symptoms which were thought to be secondary to peripheral arterial insufficiency; these in turn had led to repeated angiograms and to a right carotid endarterectomy at age 54. Since that operation she had suffered from a 'cold left arm' associated with almost daily anginal pains, the latter being well controlled by sublingual tablets of nitroglycerin and oral propanolol. Routine medications at home consisted of sublingual nitroglycerine, digitalis and propanolol (10 mgm orally three times per day).

She stated that, following the ingestion of propanolol, she had felt well for awhile and that thereafter the only complaints had been progressive weakness, mild nausea and dizziness which

had led to her request that she be brought to the hospital.

Following admission to the Intensive Care Unit her condition appeared to be satisfactory in spite of the fact that the blood pressure could not be measured. Eventually, and in order to resolve the apparent anomaly of a "well" patient without a measurable blood pressure, a #16 Teflon® cannula was inserted percutaneously in the right femoral artery and the blood pressure was then measured via a strain gauge and oscilloscope system. The waveform which was observed was entirely normal and the observed values were 120 mm Hg systolic and 80 mm Hg diastolic. In view of these findings, therapeutic efforts were limited to support of the plasma and extracellular water compartment as well as support of the renal function (Table 1).



KENNETH A. PEART, M.D., is a specialist in family medicine and obstetrics affiliated with the Southern Illinois Clinic, Ltd., in Mount Vernon, IL.

Dr. Peart earned his M.D. from the University of Illinois Medical School in 1958, and is the former chief of outpatient services for Darnall Army Hospital, Ft. Hood, Texas.



ANTONIO BOBA, M.D., is Director of Anesthesia at the Southern Illinois Clinic, Ltd., in Mt. Vernon. Dr. Boba has done extensive research in the development of a system analysis approach to anesthesia as a process.

TABLE 1

Fluid Intake	
(first eight hours after admission)	
5.0% glucose/water	800 ml
Lactated Ringer's	2500 ml
Dextran 40 in 0.9% NaCl	500 ml
Mannitol 10% in water	750 ml
Oral	none
Urinary Output	
(first eight hours after admission)	
volume	2600 ml
Sodium (total mEq loss)	117
Potassium (total mEq loss)	18
Chloride (total mEq loss)	122

During the night the blood pressure and the pulse rate remained fairly stable and at 08.00 of the following morning when the blood pressure was checked with the sphygmomanometer



it was found to be in close agreement with that registered on the oscilloscope. The femoral arterial cannula was then removed and the patient allowed to resume oral intake 'ad lib'. Also, at this time it was noted that the patient could sit up in bed without complaining of dizziness, and nausea was no longer reported.

She made an uneventful recovery but for the recurrence of anginal pains which were treated and controlled with sublingual nitroglycerin and oral propranolol. Parenthetically, one should note that cardiac enzymes determinations, which had been made immediately upon admission and daily thereafter for three days, were consistently within normal limits and that daily electrocardiograms failed to reveal changes from the admission pattern.

### Comments

The events, as related and recorded, indicate that the patient ingested propranolol for the purpose of inducing at least some harm, possibly self-destruction. It is true that the absolute dose

that was ingested was not very large in an absolute sense,<sup>1</sup> yet considering her daily and single doses one finds that she did ingest at one sitting 40 times her usual effective single dose and more than 12 times her aggregate daily dosage. Within this frame of reference she did in fact ingest an 'overdose'.

The successful management of the patient's condition without resorting to specific antidotes should not come as a surprise, once one remembers that propranolol has a pure blocking action and that neither it nor any of its intermediate metabolites have intrinsic toxic properties.

The poor performance of the sphygmomanometer should have been anticipated in view of the known observer's<sup>2</sup> and systematic errors<sup>3</sup> which beset the technique. It is important to note that in this instance, had the "no pressure" report been accepted at face value, then inappropriate therapeutic measures might have been undertaken.

In summary then, a 56-year-old patient ingested deliberately at one sitting 40 times her usual therapeutically

effective dose of propranolol. Subjective complaints were limited to nausea and dizziness. No objective manifestations of the drug could be demonstrated but for the fact that the blood pressure could not be measured with the sphygmomanometer but was found to be within normal limits when measured by means of an intra-arterial needle-strain gauge-oscilloscope system. The patient made an uneventful and uncomplicated recovery without the need of specific therapy.

### References

1. Zacharias, F. J., Cowen, K. J., Presst, J., Vickers, J. and Wall, R. J.; "Propranolol in Hypertension: A Study of Long-term Therapy," 1964-1970. *Am. Heart Journ.*, vol. 82, p. 755, June, 1972.
2. Wilcox, J.; "Observer Factors in the Measurement of the Blood Pressure," *JAMA*, vol. 179, p. 53, Jan. 6, 1962.
3. Afifi, A. A.; "Accuracy of Blood Pressure Measurement in Patients with Acute Hypotension and Shock," *Journal of Trauma*, vol. 9, p. 145, Feb. 1969.

# Treat yourself to a day, a week end or an entire week!

This week get away from it all! Lake Lawn Lodge has the restful atmosphere you need to unwind. Call Chicago (312) 372-6062 for reservations, or call or write us directly.



## LAKE LAWN LODGE

Box M, Delavan, WI 53115  
Phone 414/728-5511



# St. Louis Encephalitis:

## *Clinical Course and Response to Corticosteroids*

BY CURTIS M. SAUER, M.D./URBANA

During August and September, 1975, several hundred cases of viral encephalitis were diagnosed in Illinois. Subsequent serologic testing confirmed that many of these patients were infected with the St. Louis virus. At the Carle Foundation Hospital during this period of time, serologic testing was requested on over 30 patients suspected of having this disease. Of these, 22 patients had a clinical course typical for viral encephalitis and 14 were ultimately diagnosed as confirmed, probable, or suspected St. Louis Encephalitis.\* Several of the remaining eight patients had only acute sera obtained and did not return for follow-up testing. Since the St. Louis virus may persist in local bird populations, the possibility of further outbreaks of encephalitis exists. Because of this, a retrospective analysis of the clinical features, treatment and course of the illness was performed.

### Materials and Methods

Only the 14 patients with serologic confirmation of infection with the St. Louis virus were included. There was no evidence of infection with any other arbovirus in these patients. All had a clinical history consistent with the diagnosis of viral meningitis or encephalitis. Lumbar punctures and routine spinal fluid cultures were performed on all patients.

### Results

Although there was a tendency for the clinical illness to be more common in the elderly, patients were seen in all age groups. (Table 1) Virtually without exception, the older patients

were more ill. Nearly all patients under age 60 had an illness consistent with aseptic meningitis. Nearly all had severe generalized headache, nuchal rigidity, and fever. (Table 2) Encephalitic features were found in only two patients in this group, one with transient mild confusion and the other generalized tremor. All patients in this group recovered without sequelae.

TABLE 1,  
Age Distribution

Age	Number of patients
0-9	1
10-19	2
20-29	2
30-39	1
40-49	1
50-59	1
60-69	2
70-79	1
80-89	3

In contrast, patients over age 60 were critically ill. All were confused, stuporous, and, in some cases, comatose during their illness. The apparent low incidence of headache (Table 2) was due, in some cases, to an inability to obtain an exact history in this group. Five had a prominent generalized tremor unassociated with other signs of cerebellar disease. Half had signs associated with frontal lobe dysfunction: paratonic rigidity and grasp, suck and palmomental reflexes. Transient hemiplegia was noted in one

\* (1) Confirmed: Fourfold rise or fall in the Hemagglutination Inhibition titer in acute and convalescent sera. (N=6)

(2.) Probable: at least one titer of 1:80 or greater. (N=6)

(3.) Suspect: at least one titer of 1:10 or greater. (N=2)

TABLE 2, Clinical Features		
	<Age 60	>Age 60
Headache	8/8	2/6
Fever	7/8	6/6
Nuchal rigidity	4/8	6/6
Abnormal neurologic exam	2/8	6/6
Stupor, coma	1/8	6/6
Tremor	1/8	5/6
"Frontal lobe" signs	0/8	3/6
Hemiparesis	0/8	1/6
Seizures	0/8	0/6

patient. No convulsions were noted in the entire series.

Cerebrospinal fluid white cell counts were elevated in all patients and, in most cases, lymphocytes predominated. **There was a significant difference in the total white cell count between the younger and older patients; in the latter group, lower cell counts were uniformly found.** (Table 3) Spinal fluid protein was normal in eight patients and mildly elevated in the remaining six maximum = 80 mgm%). Spinal fluid sugars and routine bacterial cultures were normal in all patients. Electroencephalograms were performed in several of the older patients and revealed generalized slowing of the background rhythm in all.

In the younger patients, fever and nuchal rigidity usually disappeared by the end of the

TABLE 3, Cerebrospinal Fluid Cell Count		
	<Age 60	>Age 60
Range	55-1359	18-47
Mean	400	32

first week of hospitalization. Generalized headache often persisted for an additional one to two weeks. All patients under age 60 recovered without sequelae. Older patients remained sick for longer periods of time and had abnormal neurologic findings which persisted for up to four weeks. Three of these patients were treated with high dosages of parenteral corticosteroids. In each case the attending physician felt that there was definite clinical improvement within 24 to 48 hours after they were started. (Table 4) In one patient (Number 4) the response was dramatic.

### Case Report

V. B., a 62-year-old lady, was admitted with a one day history of fever, headache, confusion and lethargy. Routine laboratory tests failed to reveal a cause for her confusion. Lumbar puncture revealed clear spinal fluid under normal pressure, but which contained 47 white cells (30 mononuclear and 17 polies). After 36 hours of therapy with penicillin she was unchanged and a neurologic consultant noted that she was semicomatose and had definite nuchal rigidity. She could not respond meaningfully to simple commands. There was no focal weakness. Intermittent Cheynes-Stokes respirations were noted.

TABLE 4, Response to Treatment in Patients > Age 60					
Patient No.	Age	Coma	Other Findings	Steroid	Outcome
1	61	Yes	Tremor, "Frontal lobe"	Yes	Gradual improvement
2	84	Yes	Tremor, "Frontal lobe"	No	Gradual improvement
3	80	Yes	Tremor	No	Incomplete recovery, death 2 mos. later
4	62	Yes	None	Yes	Dramatic improvement
5	72	Yes	Tremor, "Frontal lobe"	No	Slow recovery
6	81	Yes	Tremor, hemiparesis	Yes	Gradual improvement over 48 hrs.

FIG. 1. PATIENT V.B. CLINICAL COURSE



Penicillin was discontinued and Decadron®, 10 mgm. i.v. followed by 4 mgm. i.v. every six hours, was begun. Within 24 hours she was afebrile, fully alert, and oriented to time, place and person. (Figure 1) She recovered uneventfully over the next several days.

## Discussion

The clinical features of this group of patients are similar to previous series.<sup>1-3</sup> Experience in other epidemics has shown that the disease is both more prevalent and more serious in the elderly.<sup>3-5</sup> Benign, self-limited aseptic meningitis was found in nearly all of the young and middle aged patients. Overall mortality and morbidity were low. No deaths were directly attributed to St. Louis Encephalitis. One elderly patient (Table 4, Number 3) was left with a profound organic dementia and died two months later from other causes. Previous epidemics have revealed mortality rates as high as 20%.<sup>1</sup> No conclusions

can be made as to whether the low mortality and morbidity of this series related to improved supportive care. An alternative possibility is that the 1975 epidemic was due to a less virulent strain of virus. As noted above, there was a significant difference in the spinal fluid white cell counts between the younger and older patients. None of the patients over age 60 had any recognizable immunologic disease. They also tended to have slightly higher antibody titers to the St. Louis virus. The differences in the spinal fluid cell counts may reflect a predilection for the virus to attack the cerebrum of the elderly and the meninges of the young.

Administration of corticosteroids was followed by clinical improvement in three patients. Beneficial effects have also been reported with the use of steroids in isolated cases of Herpes Simplex Encephalitis.<sup>6,7</sup> There is, however, no conclusive evidence that they affect the ultimate course of the later disease. Despite theoretic objections, their use would appear justified in selected pa-



tients with St. Louis Encephalitis. The reasons for the observed clinical improvement in these patients are unclear. With the exception of the patient with Cheynes-Stokes respirations, no patient had signs of impending or actual transitory herniation. Spinal fluid pressures were normal in all patients. It is tempting to speculate that the usefulness of steroids in these patients was related to suppression of cell mediated inflammatory responses within the central nervous system. ◀

#### References

1. Baker A. B. Editor: "Viral Encephalitis," CLINICAL NEUROLOGY. Harper and Rowe, 1974, vol. 2, chapter 17, pp 11-12.
2. Southern D. M., Smith J. W., Luby J. P., Barnett J. A. and Sanford J. P.: "Clinical and Laboratory Features of Epidemic St. Louis Encephalitis," *Ann. Int. Med.* 71:681-689, 1969.

3. Riggs S., Smith D. L., Phillips C. A.: "St. Louis Encephalitis in Adults During the 1964 Houston Epidemic," *JAMA* 193:284-288, 1965.
4. Hopkins C. C., Hollinger F. B., Johnson R. F., Dewlett H. J., Newhouse V. F., Chamberlain R. W.: "The Epidemiology of St. Louis Encephalitis in Dallas, Texas 1966," *Am. J. Epidem.* 102:1-15, 1975.
5. Rubin R. H., Glick T. H., Rose, N. R.: "St. Louis Encephalitis in Saline County, Illinois, 1968," *J. Inf. Dis.* 122:347-353, 1970.
6. Johnson K. P., Rosenthal M. S., Lerner P. I.: "Herpes Simplex Encephalitis," *Arch. Neurol.* 27:103-108, 1972.
7. Upton A. R. M., Barwick D. D., Foster J. B.: "Dexamethasone Treatment in Herpes Simplex Encephalitis," *Lancet* 1:290-291, 1971.

**CURTIS M. SAUER, M.D.**, is a neurologist affiliated with the Carle Clinic Association in Urbana. He is also a clinical associate in the School of Basic Sciences for the University of Illinois School of Medicine at Champaign-Urbana.

## LOW-COST GROUP INSURANCE ANOTHER ISMS MEMBERSHIP PRIVILEGE

FOR INFORMATION,  
ASSISTANCE  
& DETAILS CONTACT:

Administrators:  
**PARKER, ALESHIRE & COMPANY**  
ESTABLISHED 1901  
*Insurance*

**THE GROUP DISABILITY PLAN** ● Provides up to \$1,732.00 monthly in the event of disability caused by Accident or Sickness. ● Special Guaranteed renewal feature. ● Protect your income and security.

**BUSINESS OVERHEAD EXPENSE PLAN** ● Pays your office overhead expense when disability strikes. ● Premiums are Tax Deductible. ● Pays in Addition to the Disability Plan Benefits.

**THE BASIC MAJOR MEDICAL EXPENSE PLAN** ● In or out of Hospital Benefits up to \$25,000.00 per Disability. ● Up to \$100.00 Daily Hospital Room and Board maximum. ● Subject to choice of deductible and 80% coinsurance.

**EXCESS MAJOR MEDICAL PLAN** ● Provides up to \$250,000 for Medical Expenses. ● Supplements any Basic Major Medical Plan and has a \$25,000 deductible. ● Low group rates. ● Truly catastrophic coverage.

9933 N. Lawler Avenue  
Skokie, Illinois 60076  
Phone: 312-679-1000

## Medical Disciplinary Board Actions

The following "Recommended Steps for Initiating Medical Society Disciplinary Action and Reporting to the Medical Disciplinary Board" were adopted by the ISMS Board of Trustees at its meeting of February 5, 1977. The Board further mandated that this information be published in *Action Report* and the *Illinois Medical Journal*, along with the names of those physicians who were disciplined by the Department of Registration and Education.

During 1976, the Department of Registration and Education imposed disciplinary action on the licenses of several physicians. Beginning in July, this was carried out through the newly created Medical Disciplinary Board. Excluded from the listing are five chiropractors who also were disciplined during this period.

### RECOMMENDED STEPS FOR INITIATING MEDICAL SOCIETY DISCIPLINARY ACTION AND REPORTING TO THE MEDICAL DISCIPLINARY BOARD

1. Request the Directors of the Department of Registration and Education and the Department of Public Aid to notify ISMS officially of all disciplinary actions taken against physicians.
2. Request hospital medical staffs to forward to

- county medical societies a report on disciplinary actions taken against staff members who are suspected of violating the Medical Practice Act. This is not to be construed, in any way, as restricting the hospital from reporting the incident to the Medical Disciplinary Board. Such reporting should be encouraged.
3. Urge county medical societies to investigate the qualifications for continued membership of any physician who has been: (A) Disciplined by the Department of Registration and Education; (B) Suspended or terminated from the Medicare or Medicaid program; (C) Suspended from a hospital staff; or (D) Convicted of a felony.
4. Inform all physicians that suspected violations of the Medical Practice Act by their colleagues should be reported to their county medical society. All cases should be reviewed by a Society committee to determine their validity. If the review indicates reasonable grounds for further inquiry and no malice appears to be involved, the case should then be forwarded to the Medical Disciplinary Board without comment or embellishment.
5. Information relative to cases undergoing formal ethical proceedings by medical societies should not be forwarded to the Medical Disciplinary Board until those proceedings are concluded, including appeals.

Licensee	Violation	Discipline	Date of Order
Charman F. Palmer 840 N. 24th St. Milwaukee, WI 36-41487	Ill. Rev. Stat. Ch. 91, Sec. 16 (4) Writing prescriptions for no medical reason	Consent Order 20 years suspension 74-115	1/5/76
Vigo T. Turley 1204 E. Wood St. Decatur, IL 36-13230	Ill. Rev. Stat., 1975 Ch. 91, Sec. 16 (19) (22) & (28) Misuse of drugs	License Revocation 76-8	2/3/76
Cornelius Kline 618-20th St. Rock Island, IL 36-21298	Ill. Rev. Stat., Ch. 91 Sec. 16a (4) (10) Sold prescriptions for no legitimate reason	License Revocation 75-49	2/18/76
Irving Ziedman 1514 Westwood Blvd. Los Angeles, CA 36-20635	Ch. 91, Sec. 16a (11) Writing prescriptions for no medical reason	License Suspension of 1 year 15 days 75-176	4/6/76
William E. Farney 930 N. Sixth St. Springfield, IL 36-25716	Ch. 91, Sec. 16a (4) Dispensing controlled substance for no legitimate medical reason	6 Month Suspension followed by one year probation* 75-48	4/29/76
Benjamin Lyne c/o Midway Hospital 1700 University Ave. St. Paul, MN 55104 previously 9421 S. Roberts Rd. Hickory Hills, IL 36-040675	Ch. 91, Section 16 (2) Convicted in Minnesota of using fraud and misrepresentation to illegally obtain narcotic drugs	Consent Order for one year suspension of Illinois license 75-95	5/24/76

\*Reversed by Circuit Court.

Licensee	Violation	Discipline	Date of Order
Kurt Heisler 1114 S. Second St. Springfield, IL 36-23585	Ch. 91, Sec. 16 a (4) Misuse of drugs	90 day suspension 1 yr. probation 75-47	6/21/76
Jules Michel 7515 W. Irving Pk. Rd. Chicago, IL 60634 36-34666	Ch. 91, Sec. 16(4) Prescribed dangerous drugs for numerous patients for no medical reason	Consent Order 60 day suspension and 3 years suspension of Illinois Controlled Substance Certificate 76-78	7/6/76
Gerald McCabe, M.D., D.O. 4301 N. Ashland Ave. Chicago, IL 60613 36-037494	Ch. 91, Sec. 16(4) & (19) Charged with writing more than 7,000 prescriptions in five (5) months for no medical reason	Immediate suspension pending hearing before Medical Disciplinary Board 76-83	7/28/76
Jordan M. Scher 8 S. Michigan Ave. Chicago, IL 36-35048	Ch. 91, Sec. 16(a), 16(2) Convicted of filing false income tax returns	Consent Order Censure 74-9	8/24/76
Clara Mae Rennolds 2110 Broadway Astoria, IL 61501 36-44949	Ch. 91, Sec. 16(a), Parag. 4, 6 & 19 Admitted that she was addicted to habit-forming drugs	Consent Order Voluntary Revocation must participate in drug Rehabilitation Program 76-121	9/2/76
John Millas formerly of 5720 W. Cermak Rd. Cicero, IL 36-24995	Ch. 91, Sec. 16 (a), (2), (4) Admitted that he on seven occasions sold prescriptions for controlled drugs to Federal Agents	Consent Order Voluntary Revocation 76-2	9/29/76
Jack A. Clark, D.O. 405 W. First St. Homer, IL 36-036	Ch. 91, Sec. 16(4) Admitted that he was guilty of unprofessional conduct in treating his patients	Consent Order Voluntary Revocation and must obtain psychiatric treatment 76-93	9/30/76
David Bruns Champaign, IL Medical Doctor	Charged with gross malpractice	Hearing conducted to revoke license	10/7/76
Henry Cordero 4609 N. Paulina Chicago, IL 36-48675	Ch. 91, Sec. 16(a)4, 16(a)9, 16(a)10, & 16(a)13 Admitted that he did not follow proper medical procedures	Consent Order Agreed to stop working for improperly operated weight reduction clinics 75-17	10/7/76
Jung Shong Wang 4500 N. Winchester Chicago, IL 36-49272	Ch. 91, Sec. 16(a)4, 16(a)9, 16(a)10, & 16(a)13 Admitted that he did not follow proper medical procedures	Consent Order Agreed to stop working for improperly operated weight reduction clinics 75-16	10/7/76
Charles Von Solbrig 6400 S. Keeler Chicago, IL 36-20023	Ch. 91, Secs. 16a (3), (4), (10) Admitted that there were problems at the Von Solbrig Memorial Hospital	Consent Order Voluntarily and Permanently Retired 75-183	10/15/76
Rodolfo E. Magsino 839 S. Elmwood Oak Park, IL 36-51939	Ch. 91, Sec. 16 (a) (2) para. 14 and 26. Pleaded guilty in U.S. District Court of aiding, abetting and procuring kick-backs by Fomaro Inc. and making false statements to Ill. Dept. of Public Aid	Consent Order two month suspension and two years probation 76-175	11/5/76
Louis Hinkle Coggs 9330 S. Vernon Ave. Chicago, IL 36-25974	Ch. 91, Sec. 16A, paragraphs 4, 19 & 23 Accused of writing prescriptions for controlled drugs for no therapeutic purpose Admitted that he wrote prescriptions for controlled drugs for no therapeutic purpose.	Suspension pending hearing 76-202	11/18/76
Muhammed Ali Navabi-Madar Chicago, IL	Moving to revoke license Charged with giving self narcotic injection during surgery.	Consent Order Revocation 76-202	12/17/76
		license not suspended at present. Before hearing board	11/28/76

\*Reversed by Circuit Court.

Licensee	Violation	Discipline	Date of Order
Ming Kow Hah 6166 N. Sheridan Road Chicago, IL 36-47323	Ch. 91, Sec. 16, Paragraph 11 License revoked in Michigan after hearing officer found that he made a general practice of prescribing Dilaudid as a remedy for pain no more severe than headaches; and did so repeatedly, without extensive diagnosis and in dosages more excessive and more frequent than prudent; demonstrated lack of proper concern for the potential addictiveness of Dilaudid.	License Revocation 76-48	11/29/76
Walter Trutenko 2501 S. Clinton Ave. Berwyn, IL 36-35781	Ch. 91, Sec. 16 (a) Paragraph 2 Found guilty of mail fraud in Federal Court	6 Months Probation Ordered to appear before Medical Examining Committee to determine if he has been rehabilitated 74-147	12/13/76
Dolores Torriente 8510 S. Prairie Chicago, IL 36-49716	Ch. 91, Sec. 3 & Sec. 16 (12) Received a medical license without passing the required examination	Revocation 74-165	12/15/76
Stefan Stojanoff 4435 N. Paulina Chicago, IL 36-49692	Ch. 91, Sec. 16 (12) Received a medical license without passing the required examination	Revocation 74-163	12/15/76
Dale Q. Furnell 2340 Territorial Road St. Paul, MN 55114 36-36595	Ch. 91, Sec. 16a (11) Revoked in California for unprofessional conduct. Also revoked in Minnesota, South Dakota and Nebraska	6 Months Suspension and ordered to appear before the Medical Disciplinary Board within 6 months or have his license automatically revoked	12/20/76

\*Reversed by Circuit Court.

## Viewbox

(Continued from page 170)

**DIAGNOSIS: Addison's Disease**—The film of 1-20-73 was taken when the patient had returned from a vacation in Hawaii. At that time she was told by a friend that she had a marvelous suntan. This alarmed the patient as she had spent her entire time in Hawaii confined to her hotel room. She had experienced nausea, vomiting, felt extremely weak, and finally managed to return to Chicago where she was hospitalized. A chest film taken at that time revealed a very small heart and one notes that her soft tissues are considerably diminished in character when compared to the later film. At that time a diagnosis of Addison's disease was confirmed and the patient was placed on hormonal replacement therapy. She returned three years later in good health. Her heart has now become normal in size and her breasts are well developed. The small heart has been attributed to a hypovolemic state, during the acute phase of Addison's disease. In about 25% of patients adrenal calcifications will be noted which may be unilateral or bilateral.

Deluxe nine story medical building, adjacent to Columbus Hospital and Lincoln Park, has suites available for immediate occupancy. Inside parking & full cleaning services. Free moving expenses & two months free rent available

DOCTORS WANTED

Suites: 350 to 6000 sq. ft. from \$8.50 per sq. ft.

**PARK PROFESSIONAL BUILDING**

467 W. Deming Pl.  
Chicago, Ill.  
641-7000

McKey & Poague, Inc., Agents



## *President's Page*

*"We have met the enemy  
and they is us"*

*Pogo*



It is difficult to defend an action based on an emotional reaction to a threat by government, when that reaction can and will lead the public to say that the medical profession is more concerned with its delicate ego and/or its pocketbook than with the public welfare.

It is tedious to point out repeatedly that any unrealistic controls applied to the private practice of medicine can ultimately be applied to any and all professions and occupations.

To argue against a proposal simply because the government is involved is unrealistic and naive. We, the people, are the government. Government is not all bad and all government is not bad.

It is our responsibility as doctors and as citizens to keep government honest and aware and responsible.

*Joseph H. Skom, M.D.*

Joseph H. Skom, M.D.

# Doctor's News

**PHYSICIANS IN THE NEWS**—ISMS President-Elect **George T. Wilkins, M.D.**, Granite City, has been appointed to the AMPAC board of directors. Dr. Wilkins has been a member of the IMPAC Council (the state-level organization) since 1970, serving as IMPAC chairman in 1975-76. During his chairmanship, Dr. Wilkins was instrumental in building IMPAC membership by over 19%. The combined family IMPAC membership which he originated is said to have resulted in a 250% increase in IMPAC contribution to AMPAC during the years 1973-76.

**Earl N. Silber, M.D.**, River Forest, has been elected president of the medical staff at Michael Reese Hospital and Medical Center in Chicago. Dr. Silber has served as chief of the Section of Education and Training for the Cardiovascular Institute, Department of Medicine at Reese. It has also been announced that **Allan Charles, M.D.**, Chicago, has been elected president-elect of the medical staff at Reese, and **Arnold Tatar, M.D.**, Highland Park, will serve as secretary-treasurer.

The Oak Park Hospital medical staff has also announced its new officers for 1977. **Frank J. Ashley, M.D.**, Elmhurst, has been elected president of the medical staff. **Roland A. Kowal, M.D.**, Elmwood Park, will serve as Vice President, **Louis P. River, III, M.D.**, Oak Park, Secretary, and **James T. Hicks, M.D.**, River Forest, Treasurer.

**Gerald S. Moss, M.D.**, Northbrook, has been named chairman of the Department of Surgery at Michael Reese Hospital and Medical Center. Dr. Moss currently holds this position at Cook County Hospital, and the appointments will be concurrent as of July 1, 1977. **Craig Stewart, M.D.**, has been elected president of the board of directors of the Barren Foundation. Dr. Stewart is an obstetrician and gynecologist from Evanston.

The University of Illinois Medical Center has announced that **Ralph Wynn, M.D.**, River Forest, has been elected president of the Chicago Gynecological Society. Dr. Wynn is head of the Department of Obstetrics and Gynecology at the UI Hospital and the Abraham Lincoln School of Medicine. **Theodore C. Doege, M.D.**, a faculty member at the University of Illinois Medical Center, has been named director of the AMA Department of Environmental, Public and Occupational Health. Dr. Doege, who specializes in preventive medicine, will take the position on May 1, 1977.

**P. R. Roy, M.D.**, Chicago, has been appointed Director of Respiratory Therapy at Martha Washington Hospital. Dr. Roy, who is also an Associate in Internal Medicine at the University of Illinois, will oversee diagnosis and treatment of cardiopulmonary disorders and postoperative treatment of respiratory complications.

**MS RESEARCH**—The Multiple Sclerosis Society has awarded a research grant to **Floyd A. Davis, M.D.**, Director of the Multiple Sclerosis Center at Rush-Presbyterian-St. Luke's Medical Center. The research project will center around the functional productivity of drugs available for MS treatment.

**NEW THOMPSON APPOINTEES**—Gov. James Thompson will submit nominees to direct Illinois health-related departments to the Illinois legislature for confirmation in the coming weeks. Robert DeVito, M.D., a psychiatrist on the faculty of the Loyola University School of Medicine and superintendent of the Madden Mental Health Center in Hines, Illinois, will be nominated to head the Department of Mental Health and Developmental Disabilities. Arthur Quern, of Alexandria, Virginia, will be proposed to head the Department of Public Aid. Mr. Quern served on former Pres. Gerald R. Ford's Domestic Council and also worked under Nelson Rockefeller in the administration of New York State government. Gov. Thompson has nominated Joan G. Anderson to serve as director of the Department of Registration and Education. Anderson, a trustee of the Metropolitan Sanitary District in Chicago, was a delegate to the 1970 Illinois Constitutional Convention and a home rule consultant and intergovernmental relations expert for the UI Institute of Government and Public Affairs. Paul Q. Peterson, M.D., has been named for director of the Illinois Department of Public Health. Dr. Peterson is currently Dean of the UI Medical Center School of Public Health. Dr. Peterson's credentials include positions as Chief in the Division of International Health, Chief of the Chronic Disease Program and also Assistant Director of the National Institute of Allergy and Infectious Diseases when he served the HEW Public Health Service. He was named Deputy Surgeon General of the Public Health Service in 1970.

**FASTING AND SURGERY**—A group of anesthesiologists at Michael Reese Hospital and Medical Center, Chicago, have proposed that fasting prior to surgery may be harmful to the patient. The research hypothesizes that a lack of glucose in the blood system causes the heart to metabolize body fats for fuel. As this requires more oxygen, and the heart is already depressed by anesthesia, it has been proposed that fasting may be a cause of cardiac arrhythmia during surgery. One solution proposed involves intravenous feeding of glucose on the day preceding surgery to prevent the heart's switching to fat metabolism.

**NEW GONORRHEA STRAIN**—The Illinois Department of Public Health has issued a warning that a new strain of penicillin-resistant gonorrhea is expected to become active in Illinois in the near future. Nearly 100 cases of the strain, penicillinase-producing *Neisseria gonorrhoeae* (PPNG) have been identified in the United States. The symptoms of PPNG are similar to those of the familiar strain of gonorrhea, and the department has suggested that all cases be tested on a return visit within five to 14 days of the initial examination. If it is determined that penicillin treatment has not been effective, retest specimens should be sent to the state laboratory to check for evidence of penicillinase activity. Spectinomycin is the only antibiotic proven effective in PPNG treatment thus far.

**PUBLIC VIEWS OF MALPRACTICE**—A recent edition of "Malpractice Lifeline" has reported the results of a national Gallup Poll assessing views of the American public on the malpractice crisis. The poll found that peer review was the best supported solution (85 v. 7% approved of self-policing physicians). Eighty percent (versus 10%) approved of fixed lawyers' fees in malpractice cases; 62% (versus 25%) favored limiting the maximum award in a malpractice suit; and 59% (versus 30%) approved the time limit of five years between treatment and initiation of a malpractice suit.

# Convention Handbook



## ANNUAL MEETING '77

**Members of the House of Delegates**

**Delegates and Alternate Delegates to the Illinois State Medical Society**  
**Downstate Delegates**  
**Chicago Medical Society**

**Officers of County Medical Societies**

**Program Summary by Days**

**ISMS Auxiliary Convention Program**

**Agenda of the House of Delegates**

**Committees of the House of Delegates**

**Resolutions**



*Physicians of  
the Illinois State Medical Society  
are cordially invited to a gala*

*President's Night  
Dinner-Dance*

*April 25, 1977*

*honoring*

**Joseph H. Skom, M.D.  
President  
Illinois State Medical Society**

*featuring*



**THE SECOND CITY**

**Dance Music by:**

**The Allen Kaye Orchestra**

*Tickets—\$20.00 per person*

# Members of the 1977 House of Delegates

## OFFICERS

President .....	Joseph Skom
President Elect .....	George Wilkins
1st Vice President .....	David S. Fox
2nd Vice President .....	Theodore Grevas
Secretary-Treasurer .....	Jacob E. Reisch
Speaker of the House .....	James A. McDonald
Vice Speaker .....	Cyril Wiggishoff

## TRUSTEES

First District .....	Joseph L. Bordenave	1977	Fourth District .....	Fred Z. White	1979
Second District .....	Allan L. Goslin	1977	Fifth District .....	Paul F. Mahon	1979
Third District .....	Alfred Clementi	1977	Sixth District .....	Robert R. Hartman	1978
	Alfred Faber	1977	Seventh District .....	Alfred J. Kiessel	1979
	Robert T. Fox	1979	Eighth District .....	James Laidlaw	1979
	Henrietta Herbolzheimer	1978	Ninth District .....	Warren D. Tuttle	1978
	Lawrence L. Hirsch	1978	Tenth District .....	Julian W. Buser	1978
	Eugene T. Hoban	1978	Eleventh District .....	Ross Hutchison	1977
	William M. Lees	1977	Twelfth District (1A) .....	P. John Seward	1977
	Joseph C. Sherrick	1977	Trustee-at-Large .....	J. M. Ingalls	
	Philip G. Thomsen	1977			
	Herman Wing	1979			

## Past Presidents

J. Ernest Breed .....	1971	Fredric D. Lake .....	1975
Edward W. Cannady .....	1970	Willis I. Lewis .....	1954
Everett P. Coleman .....	1945-46	Burtis E. Montgomery .....	1966
Newton DuPuy .....	1968	Edward A. Piszczek .....	1965
Harlan English .....	1964	Caesar Portes .....	1967
Edwin S. Hamilton .....	1962	Willard C. Scrivner .....	1974
H. Close Hesseltine .....	1961	Leo P. A. Sweeney .....	1953
J. M. Ingalls .....	1976	Philip G. Thomsen .....	1969
C. J. Jannings, III .....	1972	Arnell M. Vaughn .....	1955
Frank J. Jirka, Jr. ....	1973		

## Delegates to AMA

Herschel Browns	Jack L. Gibbs	Edward A. Piszczek
Allison Burdick, Jr.	Theodore Grevas	John Ring
Howard C. Burkhead	Lawrence N. Hirsch	Fred A. Tworoger
Alfred J. Faber	Morgan M. Meyer	Charles K. Wells
David S. Fox	Joseph R. O'Donnell	

## Past Trustees or Councilors

Earl H. Blair .....	Third District	Eugene P. Johnson .....	Eighth District
Walter C. Bornemeier .....	Third District	Ted LeBoy .....	Third District
Carl E. Clark .....	First District	A. Edward Livingston .....	Fifth District
Samuel Cloninger .....	Third District	Joseph R. O'Donnell .....	Eleventh District
Herbert Dexheimer .....	Tenth District	Mather Pfiennenberger .....	Sixth District
David S. Fox .....	Third District	Ralph N. Redmond .....	Second District
Willard W. Fullerton .....	Tenth District	George Shropshire .....	Third District
George E. Giffin .....	Second District	Darrell H. Trumpe .....	Fifth District
Arthur F. Goodyear .....	Seventh District	Frederick E. Weiss .....	Third District
Lee N. Hamm .....	Fifth District	Charles K. Wells .....	Ninth District
		Paul P. Youngberg .....	Fourth District

# Delegates and Alternate Delegates to the Illinois State Medical Society

## DOWNSTATE DELEGATES

County	Delegates	Alternate	County	Delegates	Alternate
ADAMS	James W. Sutherland	Walter Stevenson, III	LOGAN	Glen E. Tomlinson	
ALEXANDER	Jesus Manalang	Gemo Wong	MACON (2)	J. Schrodt	C. O. Stanley
BOND	M. K. Kaufman	Boyd McCracken		D. Statzer	
BOONE	John Steinkamp	M. J. Carlisle	MACOUPIN	Robert G. England	A. E. Villasanor
BUREAU	Louis Lukancic	James Foreman	MADISON (2)	E. K. DuVivier	Edward Ragsdale
CARROLL	L. B. Hussey	C. G. Piper		Robert F. Hamilton	Lawrence Heineman
CASS-BROWN			MARION	Walter P. Plassman	Hamid Mahmud
CHAMPAIGN (3)	Harold J. Kolb	Homer Hindman	MASON	Jack Means	Donald Stehr
	Frank Kresca	Michael Russo	MASSAC		
	Richard Helfrich	Harlan J. Failor	MCDONOUGH	J. S. Goncher	S. M. Gines
CHRISTIAN	M. T. Salaymeh	E. Doyle Slifer	MCHEERY	August M. Rosetti	Ted L. Rolander
CLARK	George T. Mitchell	Eugene Johnson	MCLEAN	Loren Boon	Robert Reardon
CLAY			MENARD		
CLINTON	W. L. DuComb	James A. Kirby	MERCER	Dennis D. Palmer	M. I. Rajput
COLES-			MONROE	Russell W. Jost	E. F. Maglasang
CUMBERLAND	M. W. Hollowell	J. R. Mallory	MONTGOMERY	Lee Johnson	
CRAWFORD	Herb Ikmayan	Dean J. Pelley	MORGAN-SCOTT	E. C. Bone	Frank B. Norbury
DEKALB	John Ovit		MOULTRIE		
DEWITT	Herman Meltzer	George Castroville	OGLE	Don E. Hinderliter	Vincent Traina
DOUGLAS	Humberto Mondul	Robert Arroll	PEORIA (4)	G. W. Giebelhausen	Gregory Spano
DUPAGE (7)	Morgan M. Meyer	John V. Ryan		Robert Flinn	Dennis Garwacki
	J. P. Campbell	Joseph P. McKay		Gene O. Hoerr	Thomas W. Clark
	Wm. C. Perkins	Robert Fitzgerald		Sam Newcomer	James Bauer
	Wm. B. Frymark	Orren D. Baab	PERRY	C. E. Cawvey	B. A. Kinsman
	Kenneth Hurst	Charles H. Westfall	PIATT	Wm. E. Mundt	George Green
	Joseph O'Donnell	Robert D. Dooley	PIKE	C. B. Lara	T. C. Bunting
EDGAR	Ramond A. Dieter, Jr.	Thomas W. Stach	PULASKI	A. L. Robinson	
EDWARDS	J. M. Ingalls		RANDOLPH	O. W. Pfisterer	J. M. Whittenberg
EFFINGHAM	Edward Krajec	Paul Neirenberg	RICHLAND	C. A. DeKovessy	Lawrence J. Knox
FAYETTE	D. N. Rames		ROCK ISLAND (3)	Richard Arnell	Frank E. Miller
FORD	Edson Etherton			Donald D. Tomlin	Marilee J. Aden
FRANKLIN	James P. Durham		ST. CLAIR (3)	James F. Duesman	Manuel O. Guerrero
FULTON	Jack L. Gibbs	R. H. Maguire, Jr.		H. Frank Holman	Donald L. Jerome
GALLATIN	John E. Doyle			Charles R. Frazer, Jr.	Joseph M. Dugan
GREENE	Jude A. Caselton	Ludwig Dech	SALINE-POPE-	Thomas P. Meirink	Mays C. Maxwell
HANCOCK	Charles F. Eddingfield	Muhammad Hafeez	HARDIN		
HENDERSON	Silvino Lindo		SANGAMON (4)	Elliott O. Partridge	C. J. Hauptman
HENRY-STARK	Richard M. Terry	William D. Larson		Robert P. Johnson	
IROQUOIS	R. K. Swedlund	James Dailey		Edward G. Ference	
JACKSON	Paul P. Lorenz	Eli L. Borkon		Robert L. Prentice	
JASPER			SCHUYLER	Twofig Arjmand	
JEFFERSON-			SHELBY	Henry C. Zingher	Robert E. Cox
HAMILTON	James R. Heersma	H. Goff Thompson, Jr.	STEPHENSON	Edwin J. Siroy	R. H. Larson
JERSEY-			TAEWELL	E. L. Vickery	J. S. Berry
CALHOUN	Bernard Baalman	Vincent Zata	UNION	John B. Sonbeck	Roger E. Neumann
JO DAVISS	Lyle A. Rachuy		VERMILION	Robert Rader	Wm. Whiting
KANE (4)	A. Beaumont Johnson	Erwin Robin	WABASH	A. M. Taylor	W. F. Hensold
	Robert Barnes	James Pritchard	WARREN	R. L. Fuller	William Walling
	Wayne Leimbach	Peter Starrett	WASHINGTON	Kenneth Ambrose	James W. Marshall
	George Shimkus	William Sheehy	WAYNE	J. L. Beguelin	
KANKAKEE	Donald Parkhurst	James Geist	WHITE	Charles J. Jannings	E. Talaga
KENDALL	Walter H. Brill		WHITESIDE	Phillip Boren	
KNOX	Jerry Ramunis	Richard M. Flacco	WILL-GRUNDY (3)	John Hubbard	Clarence Mueller
LAKE (5)	John Ring	Arthur A. Woloshin		Guy A. Pandola	Kenneth Umanski
	David Helberg	Richard Hawkins		Merle L. Otto	Albert Wm. Ray, Jr.
	Earl Klaren	Homer Goldstein	WILLIAMSON	Robert J. Becker	John D. Walter
	Eugene Pitts	Silverio Agujar	WINNEBAGO (4)	Herbert V. Fine	Daniel Roth
	Hugh Falls	James Creath		Robert H. Behmer	R. Glenn Smith
LA SALLE	E. J. Fesco	Richard Schmidt		E. T. Leonard	Robert Heerens
LAWRENCE	Robert C. Kirkwood	Larry Herron	WOODFORD	F. H. Riordan	
LEE	Donald Edwards	Kyu Jin Cho	STUDENTS	Harry W. Darland	Kazimieras Vascious
LIVINGSTON	Karl Deterding	John Purnell	HOUSESTAFF	Victor Jay	David Hopp
				William Dunn	K. Thomas Papreck
				Paul Stromborg	

## Chicago Medical Society

### Delegates

Ackley, William O.  
Andelman, Samuel L.  
Bjornsson, Leif  
Blankshain, Richard  
Brislen, Andrew J.  
Brown, Finley W. Jr.  
Browns, Herschel L.  
Budrys, Stanley  
Burdick, Allison L., Sr.  
Burkhead, Howard C.  
Chamberlain, Danford O.  
Ciskoski, Roland J.

Cohen, Meyer B.  
Costanzo, Vincent A.  
Cross, Roland R.  
Des Rosiers, Raymond J.  
Dragisic, Branislav M.  
Faber, Alfred J.  
Falloon, Edwin L.  
Filipowicz, Roman I.  
Fischer, Arthur R.  
FitzGibbons, James P.  
Flaherty, Bernard P.

Flanagan, C. Larkin  
Freda, Vincent C.  
Freidheim, Jere  
Friedell, Morris T.  
Friefeld, Nathan  
Gertz, George  
Guerrero, Severo K., Jr.  
Hamilton, Robert C.  
Hamilton, Samuel  
Harrod, John P., Jr.  
Hesseltine, H. Close

Hinkamp, Joseph F.  
Horton, Loren B.  
Hrejsa, Allen C.  
Hussey, Frank L., Sr.  
Hutchison, William A.  
Hyde, John S.  
Jamieson, Rodney  
Jirka, Frank J., Jr.  
Joslyn, A. Everett, Jr.  
Kaz, Alex H.  
Kirschenbaum, M. Barry

Klinger, Alfred D.  
Kowal, Roland A.  
Kozak, John A.  
Kunis, Arthur  
Kwinn, Frank C.  
Lagorio, George L.  
Lasky, Harold J.  
Lobraico, Rocco V., Jr.  
Lounsbury, B. Franklin  
Lukaszewski, Edwin J.  
MacNerland, Robert H.

### Alternate Delegates

Andersen, James H.  
Ashley, William F.  
Banich, Francis E.  
Banuchi, Fedor F.  
Beck, Charles A.  
Bild, Sidney  
Borden, Nicholas J.  
Borelli, Nelson  
Burdick, Allison L., Jr.  
Burke, Edward A.  
Byrne, Mitchel P.  
Cermak, Miles

Chaljub, Najib  
Christensen, Eldis M.  
Clemis, Jack D.  
Cohen, Gerald  
Colbert, Maurice  
Constantaras, Alexander  
De La Mata, Augustin  
De Rose, William F.  
De Trana, Frank A.  
Diffenbaugh, Willis G.  
Farah, George S.

Ford, James W.  
Frankel, Jerome J.  
Galindo, Olimpo  
Gau, Frederick  
Gnade, Gerard R.  
Goldstein, Henry A.  
Graham, James F.  
Green Martin W.  
Gross, Alvin  
Handler, Jerome L.  
Heller, Philip H.

Hemwall, Gustav A.  
Hudec, Ronald L.  
Hussey, Frank L., Jr.  
Jacobs, W. Francis  
John, Thomas  
Johnson, Theodore  
Jones, Richard  
Juhasz, John C.  
Kalsch, Harry E.  
Kash, Harold M.  
Khan, Abdul Haye

Kobak, Mathew W.  
Krolikowski, John R.  
Lawrence, Arthur G.  
Lipsich, Michael  
McCabe, Mary Joan  
Mella, Luis  
Mikhail, Kamel A.  
Muehrcke, Robert C.  
Munoz, Maria  
Murphy, Thomas E.  
Nainis, William S.

### Delegates

Marcus, Anna A.  
Markoutsas, George C.  
Marshall, William  
McCartney, Charles P.  
Mehlinger, Kermit T.  
Meisenheimer, Martin P.  
Moles, Joseph B.  
Murphy, Daniel J.  
Murray, Meredith B.  
Mustell, Robert R.  
Nagel, Frank E.  
Nemecek, Raymond W.

Neskodny, J. F.  
Nicholas, Everett E.  
Norberg, Clarence A.  
O'Brien, James C.  
O'Donnell, John W.  
Okner, Henry B.  
Palumbo, Carl F.  
Patlak, Erwin M.  
Peterson, Arthur R.  
Petty, David T.  
Quinlan, Donald

Razim, Edward A.  
Reeder, Clifton L.  
Rice, C. Malcolm Jr.  
Rothstein, David A.  
Ruiz, Gonzalo  
Ruzich, Stanley  
Sarley, Vincent C.  
Schlageter, Charles W.  
Shapiro, Maynard I.  
Shobris, Martin  
Smith, C. Otis

Smith, William  
Soboroff, Burton J.  
Sofield, Harold  
Solon, Earl N.  
Sperling, Richard L.  
Suckow, Earl N.  
Tansey, William J.  
Thompson, J. Robert  
Thomson, Andrew  
Tope, John W.  
Tovar, Jorge

Turner, George C.  
Tworoger, Fred A.  
Walkowiak, Lydia  
Waller, Jesse E.  
Weigel, Charles J.  
Weingarten, Charles Z.  
Wichowski, Walter A.  
Williams, Jack  
Xydakis, Stephanos A.  
Yancez, Frank  
Yatvin, Harold

### Alternate Delegates

Nikurs, Lydia  
Nowak, Frank J.  
Nyhuss, Lloyd M.  
Odiaga-Garcia, Ignacio  
Oliver, Adriano S.  
Olivieri, Ernest P.  
O'Neil, Colman J.  
Oselka, Adam  
Panayotou, Irene  
Pantone, Anton M.  
Parisi, Frank  
Paull, Murry M.

Pedroso, Aldo F.  
Perritt, Richard A.  
Pill, Michael  
Pleotis, Peter  
Prombo, Marjorie P.  
Pruc, Jeremias N.  
Rodriguez, Douglas D.  
Rowlette, Raymond S.  
Roy, Shirley  
Ruane, Michael  
Saltiel, Isaac

Schifano, Joseph  
Schimel, Samuel J.  
Scruggs, Charles  
Seed, Randolph W.  
Seskind, Coleman R.  
Siedlinski, John E.  
Sinaiko, Edwin S.  
Singh, Nerissa P.  
Spinka, Harold  
Springer, Harry A.  
Staley, Warren H.

Strohl, Lee H.  
Stromberg, William B., Jr.  
Tatooles, Constantine J.  
Treister, Michael R.  
Ungar, Jacob  
Urban, Conrad J.  
Valadka, Bronius  
Yanong, Pao U.  
Zitlik, Russell W.



# Officers of County Medical Societies

## 1977

COUNTY	PRESIDENT	SECRETARY
ADAMS Members: 94-Dist. 6 Maxine Boyer, Ex. Sec. 1118 Broadway Quincy 62301	Givi Gabliani W.C.U. Bldg., Quincy 62301	Kazem Attai 1101 Maine, Quincy 62301
ALEXANDER Members: 9-Dist. 9	Gemo Wong 2020 Cedar, Cairo 62914	Charles L. Yarbrough 800 Commercial, Cairo 62914
BOND Members: 8-Dist. 7	M. Kenneth Kaufmann 105 E. College, Greenville 62246	John K. Dawdy 404 Forest Lane, Greenville 62246
BOONE Members: 14-Dist. 12 (1A)	Earl S. Davis 119 S. State, Belvidere 61008	John Steinkamp 824 S. Van Buren, Belvidere 61008
BUREAU Members: 37-Dist. 2	Gerald Levisay 682 E. Peru, Princeton 61356	Donald M. Gallagher Box 538, Granville 61326
CARROLL Members: 7-Dist. 12 (1A)	Basilios Lambos Broad St., Lanark 61046	Eliseo M. Colli 102 E. Washington, Mt. Carroll 61053
CASS-BROWN Members: 3-Dist. 6	R. A. Spencer 115 W. 4th St., Beardstown 62618	B. A. DeSulis 115 W. 4th St., Beardstown 62618
CHAMPAIGN Members: 195-Dist. 8 Larry Booth, Ex. Sec. 1408 W. University Urbana, 61801	Richard C. Adams 302 E. Stoughton, Champaign 61820	H. Ewing Wachter 2108 W. Springfield, Champaign 61820
CHRISTIAN Members: 25-Dist. 7	E. N. Fabi 217 S. Locust, Pana 62557	I. Del Valle 311 S. Main, Taylorville 62568
CLARK Members: 7-Dist. 8	Howard G. Johnson Casey Medical Center, Casey 62420	Cecil L. Watson Marshall 62441
CLAY Members: 8-Dist. 7	A. Paul Naney Flora Clinic, Flora 62839	Donald L. Bunnell Flora Clinic, Flora 62839
CLINTON Members: 12-Dist. 7	Wilson L. DuComb 560 8th St., Carlyle 62231	Robert D. Roane 1131 Fairfax St., Carlyle 62231
COLES-CUMBERLAND Members: 41-Dist. 8	Narayan Amin 1700 Wabash Ave., Mattoon 61938	Asit P. Basu 501 Jackson Ave., Charleston 61920
COOK Members: 8627-Dist. 3 Robert Lindley, Ex. Adm. 310 S. Michigan Ave. Chicago 60604	Herschel L. Browns 4600 N. Ravenswood, Chicago 60640	Charles W. Schlageter 707 N. Fairbanks, Chicago 60611
CRAWFORD Members: 14-Dist. 8	Dean J. Pelley Allen Clinic, Robinson 62454	Thomas P. Sloan 306 N. Prairie Street, Robinson 62454
DE KALB Members: 58-Dist. 12 (1A)	Frank E. Luedtke 235 S. Third St., DeKalb 60115	Loren W. Akers Northern Ill. Univ., DeKalb 60115
DE WITT Members: 12-Dist. 5	John W. Veirs 219 E. Main, Clinton 61727	George Castroville 109 S. Main, Farmer City 61842
DOUGLAS Members: 9-Dist. 8	Walter Steiner 140 W. Sale Street, Tuscola 61953	Humberto Mondul 111 W. South Central, Tuscola 61953
DU PAGE Members: 549-Dist. 11 Lillian Widmer, Ex. Sec. 26 W. St. Charles Rd. Lombard, IL 60148	Raymond A. Dieter, Jr. 454 Pennsylvania, Glen Ellyn 60137	James P. Campbell 322 N. Blanchard, Wheaton 60187

COUNTY	PRESIDENT	SECRETARY
EDGAR Members: 17-Dist. 8	J. R. Shackelford 502 Shaw, Paris 61944	J. M. Ingalls 502 Shaw, Paris 61944
EDWARDS Members: 3-Dist. 9	Paul S. Neirenberg 7 W. Main, Albion 62806	Andrew Krajec 108 W. South St., West Salem 62476
EFFINGHAM Members: 20-Dist. 7	John A. Chalstrom 416 W. Virginia, Effingham 62401	Donald Sweazy 806 N. 3rd St., Effingham 62401
FAYETTE Members: 8-Dist. 7	D. H. Rames 1029 N. 8th, Vandalia 62471	Hans Rollinger 1003 N. 8th St., Vandalia 62471
FORD Members: 14-Dist. 11	William A. Garrett Sibley 61773	Paul W. Sunderland 214 N. Sangamon, Gibson City 60936
FRANKLIN Members: 30-Dist. 9	James P. Durham Benton Med. Clinic, Benton 62812	D. P. Richerson P.O. Box 99, Christopher 62822
FULTON Members: 29-Dist. 4	Julius Manber Graham Hospital, Canton 61520	Marvin E. Schmidt Graham Hospital, Canton 61520
GALLATIN Members: 2-Dist. 9		John E. Doyle Ridgway 62979
GREENE Members: 7-Dist. 6	Jose Parcon 9th St., Carrollton 62016	James C. Reid Fillager Mem. Clinic, Greenfield 62044
HANCOCK Members: 11-Dist. 4	Vasant Pawar Memorial Hospital, Carthage 62321	James E. Coeur 630 Locust, Carthage 62321
HENDERSON Members: 1-Dist. 4	Silvino Lindo, Jr. Biggsville 61418	
HENRY-STARK Members: 35-Dist. 4	William D. Larson 110 S. Depot St., Annawan 61234	Donald R. Ford 648 N. Chicago St., Geneseo 61254
IROQUOIS Members: 19-Dist. 11	John Courtright Roberts Clinic, Watseka 60970	Mohammed M. Razvi P.O. Box V347, Watseka 60970
JACKSON Members: 60-Dist. 9	Walter H. Clarke, M.D. Carbondale Clinic Post Office Box 2347 1211 S. Independence Blvd. Carbondale 62901	Roger N. Klam Box 2347, Carbondale 62901
JASPER Members: 2-Dist. 8	Don L. Hartrich 1211 W. Jourdan, Newton 62448	Monico Low 609 S. Van Buren, Newton 62448
JEFFERSON-HAMILTON Members: 34-Dist. 9	Prince B. Oliver 2810 Lime, Mt. Vernon 62864	Antonio Boba P.O. Box 643, Mt. Vernon 62864
JERSEY-CALHOUN Members: 8-Dist. 12 (1A)	Bernard Baalman Medical Center, Hardin 62047	
JO DAVIESS Members: 8-Dist. 12 (1A)	William Gillies 300 Summit St., Galena 61036	David Hockman 300 Summit St., Galena 61036
KANE Members: 301-Dist. 1 Michael Wild, Ex. Dir. 11 S. 2nd St. Geneva 60134	David J. Clark 1870 W. Galena Blvd., Aurora 60506	Gerald Liesen 606 S. Riverside, St. Charles 60174
KANKAKEE Members: 103-Dist. 11	Bernard E. Ruder 401 N. Wall St., Kankakee 60901	A. A. Palow 475 W. Merchant, Kankakee 60901
KENDALL Members: 6-Dist. 11	Walter Brill Main St., Oswego 60543	John P. Cullinan Oswego 60543
KNOX Members: 73-Dist. 4	John J. Holland 501 Bondi Blvd., Galesburg 61401	Robert J. Nelson Galesburg Cottage Hosp., Galesburg 61401
LAKE Members: 342-Dist. 1 Julia Schulz, Ex. Sec. P.O. Box 148 Gurnee, Ill. 60031	Peter Vinciguerra 200 N. Milwaukee, Libertyville 60048	Albino Bismonte 135 N. Greenleaf St., Gurnee 60031

COUNTY	PRESIDENT	SECRETARY
LA SALLE Members: 106-Dist. 2	A. O'Berto 827 E. Norris Dr., Ottawa 61350	Allan L. Goslin 712 N. Bloomington, Streator 61364
LAWRENCE Members: 9-Dist. 8 Ruth Gariepy, Ex. Sec. Lawrence City Mem. Hosp. Lawrenceville 62439	Robert J. Nichols P.O. Box 907, Vincennes, Ind. 47591	Alexander Po R.R. #2, Lawrenceville 62439
LEE Members: 21-Dist. 12 (1A)	George S. Silvest White Oaks, R.R. 3, Dixon 61021	Tiam Lie 1204 Beech Dr., Dixon 61021
LIVINGSTON Members: 29-Dist. 2	Norbert Kokotek Fairbury 61739	Karl T. Deterding 612 E. Water, Pontiac 61764
LOGAN Members: 23-Dist. 5	Glen Tomlinson #4 Doctor's Park, Lincoln 62656	Robert Brown Perry 523 N. Elm, Lincoln 62656
MACON Members: 150-Dist. 7 Mary J. Bretz, Ex. Sec. 1800 E. Lake Shore Dr. Decatur 62521	W. C. Simon 1807 N. Edward, Decatur 62526	Ezra Beyda 2220 N. Monroe, Decatur 62521
MACOUPIN Members: 21-Dist. 6	Robert H. Rutherford 224 E. Main, Carlinville 62626	Robert England 224 E. Main, Carlinville 62626
MADISON Members: 168-Dist. 6	Edward K. DuVivier 1900 Brown St., Alton 62002	Norman E. Taylor 95 S. 9th St., E. Alton 62024
MARION Members: 40-Dist. 7	C. K. Fischer 1045 E. McCord St., Centralia 62801	W. P. Plassman Box 552, Centralia 62801
MASON Members: 6-Dist. 5	Henry W. Maxfield 315 E. Chestnut, Mason City 62664	
MASSAC Members 3-Dist. 9	Verachai Luangjamekorn Memorial Heights, Metropolis 62960	Benito Bajuyo 710 Catherine St., Metropolis 62960
McDONOUGH Members: 36-Dist. 4	Trevert L. Couden 501 E. Grant, Macomb 61455	Stephen L. Roth Box 258, Colchester 62326
McHENRY Members: 87-Dist. 1 Evelyn Rosulek, Ex. Sec. 308 E. Kimball Woodstock 60098	Aniceto M. D'Sousa 1110 Green St., McHenry 60050	Ted L. Rolander 1110 N. Green St., McHenry 60050
McLEAN Members: 114-Dist. 5 Bernyce Carbery Exec. Sec. 401 W. Virginia Normal 61761	Owen Deneen 326 Fairway Dr., Bloomington 61701	Douglas R. Bey 900 Franklin Ave., Normal 61761
MENARD Members: 0-Dist. 5	Robert J. Schafer 116 N. 5th, Petersburg 62675	
MERCER Members: 6-Dist. 4	Monty P. McClellan 309 NW 2nd St., Aledo 61231	James W. Hastings 301 NW 2nd St., Aledo 61231
MONROE Members: 9-Dist. 10	Edilberto F. Maglasang 109 W. Legion, Columbia 62236	Chung H. Khan Route 1, Maestown Rd., Waterloo 62298
MONTGOMERY Members: 21-Dist. 5	Lon D. Rademacher 28 Briarwood, Hillsboro 62049	James T. Foster 8 Arrowhead Rd., Litchfield 62056
MORGAN-SCOTT Members: 44-Dist. 6	James L. Green 800 W. State St., Jacksonville 62650	Ramesh Dave Passavant Memorial Hospital 1600 W. Walnut St., Jacksonville 62650
MOULTRIE Members: 5-Dist.-7	Phillip Best 14 N. Washington, Sullivan 61951	Dean McLaughlin 112 E. Harrison, Sullivan 61951

COUNTY	PRESIDENT	SECRETARY
OGLE Members: 15-Dist. 12 (1A)	L. T. Koritz 324 Lincoln, Rochelle 61068	Russell Zack 915 Caron, Rochelle 61068
PEORIA Members: 319-Dist. 4 Gerald M. Witon, Ex. Sec. 427 1st National Bank Peoria 61602	Ernest Adams 300 E. War Memorial Dr., Peoria 61614	Joseph O. Dean, Jr. Proctor Community Hosp., Peoria 61614
PERRY Members: 17-Dist. 10	Gene Stotlar 13 N. Walnut St., Pinckneyville 62274	Bill R. Fulk 207 E. Main, DuQuoin 62832
PIATT Members: 4-Dist. 7	George Green 121 N. State, Monticello 61856	Joseph Allman 121 N. State, Monticello 61856
PIKE Members: 11-Dist. 6	J. M. Bailis 112 W. Jefferson, Pittsfield 62363	T. C. Bunting 321 W. Washington, Pittsfield 62363
PULASKI Members: 1-Dist. 9	A. L. Robinson Box 277, Mounds 62964	
RANDOLPH Members: 19-Dist. 10	D. Tangsatwinsirikul 333 Locust, Red Bud 62267	C. S. Schlageter 818 E. Broadway, Sparta 62286
RICHLAND Members: 27-Dist. 8	I. Keith Edwards 1200 N. East, Olney 62450	Lawrence J. Knox 1200 N. East, Olney 62450
ROCK ISLAND Members: 187-Dist. 4 James A. Koch, Ex. Sec. 612 Kahl Bldg. Davenport, Iowa 52801	Clement P. Cunningham 2701 17th St., Rock Island 61201	E. D. Lardner 3637 23rd Ave., Moline 61265
ST. CLAIR Members: 252-Dist. 10 Ed Belz, Ex. Sec. 4825 W. Main Belleville 62223	John M. Tierney 301 W. Lincoln, Belleville 62221	Paul Rusnack St. Elizabeth's Hosp., Belleville 62220
SALINE-POPE-HARDIN Members: 30-Dist. 9	Harold E. Elliott 203 N. Vine, Harrisburg 62946	Warren R. Dammers P.O. Box 281, Harrisburg 62946
SANGAMON Members: 270-Dist. 5 L. R. Brosi, Ex. Dir. 2100 Lindsay Rd. Springfield 62704	Robert L. Prentice 701 N. Walnut, Springfield 62702	Towfig Arjmand 1209 S. Fourth, Springfield 62704
SCHUYLER Members: 4-Dist. 4	R. R. Dohner 103 W. Washington, Rushville 62681	Henry C. Zingher West Side Square, Rushville 62681
SHELBY Members: 8-Dist. 7	Sompong Trakarnpan P.O. Box 169, Shelbyville 62565	Otto G. Kauder P.O. Box 395, Shelbyville 62565
STEPHENSON Members: 50-Dist. 12 (1A)	C. W. Metcalf 1036 W. Stephenson, Freeport 61032	R. Goodspeed 1036 W. Stephenson, Freeport 61032
TAZEWELL Members: 51-Dist. 5 Colleen Ingersoll, Exec. Sec. P.O. Box 778 Pekin 61554	Robert M. Wright P.O. Box 778, Pekin 61554	Daniel L. Parr P.O. Box 778, Pekin 61554
UNION Members: 9-Dist. 9	Robert L. Rader 200 N. Main St., Anna 62906	William H. Whiting Box 410, Anna 62906
VERMILION Members: 98-Dist. 8	Manuel Agusti 605 N. Logan, Danville 61832	L. W. Tanner 7 N. Virginia, Danville 61832
WABASH Members: 7-Dist. 9	T. R. Young 512 Market St., Mt. Carmel 62863	C. L. Johns 114 W. 5th St., Mt. Carmel 62863



COUNTY	PRESIDENT	SECRETARY
WARREN Members: 13-Dist. 4	Russell Jensen 319 N. Main, Monmouth 61462	Glenn W. Chamberlin 219 E. Euclid, Monmouth 61462
WASHINGTON Members: 3-Dist. 10	Charles Longwell 111 S. Washington, Nashville 62263	Jerry L. Beguelin Box 197, Irvington 62848
WAYNE Members: 8-Dist. 9	D. A. Gershenson 308 E. Main, Fairfield 62837	Yong In Cho 101 E. Center St., Fairfield 62837
WHITE Members: 8-Dist. 9	Phillip D. Boren South Plum St., Carmi 62821	Julius G. Harrell South Plum St., Carmi 62821
WHITESIDE Members: 41-Dist. 12 (1A)	J. P. McGee 1716 Locust, Sterling 61081	Jose Pino 1913 Avenue F, Sterling 61081
WILL-GRUNDY Members: 221-Dist. 11 Ron Bryant, Ex. Sec. 3033 W. Jefferson Suite 220 Joliet 60435	Stanley G. Rousonelos 3033 W. Jefferson, Joliet 60435	Noel M. Bass 3033 W. Jefferson, Joliet 60435
WILLIAMSON Members: 34-Dist. 9	Cornelio P. Katubig Marion Mem. Hosp., Marion 62959	Herbert V. Fine 110 N. Division, Carterville 62918
WINNEBAGO Members: 373-Dist. 12 (1A) Mrs. Johanna Lund Exec. Adm. 310 N. Wyman St. Rockford 61101	Joseph B. Perez 5670 E. State St., Rockford 61108	Brian Tugana 5670 E. State St., Rockford 61108
WOODFORD Members: 6-Dist. 2	Robert Lykebak 399 Front St., El Paso 61738	James W. Riley 109 S. Major, Eureka 61530

#### No Organized County Society

Johnson  
Marshall  
Putnam

#### Joint County Societies

Cass-Brown      Jersey-Calhoun  
Coles-Cumberland      Morgan-Scott  
Henry-Stark      Saline-Pope-Hardin  
Jefferson-Hamilton      Will-Grundy

The Illinois State Medical Society has developed the council and committee structure to facilitate the activities and responses of its members. Council and committee members are selected annually, based on suggestions and nominations of trustees, delegates, and county medical societies. Appointments are made by the Chairman of the Board of Trustees, with approval of the Board.

Please notify your trustee if you wish to be considered for appointment. The various activities are as listed in the Reference Issue (October). Members who wish to notify Chairman of the Board of their availability can clip and submit the coupon below.

NAME: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_ ZIP: \_\_\_\_\_

TELEPHONE: (      ) \_\_\_\_\_

COUNTY MEDICAL SOCIETY: \_\_\_\_\_

MEDICAL SPECIALTY AND TYPE OF PRACTICE \_\_\_\_\_

COMMITTEE IN WHICH INTERESTED: \_\_\_\_\_

EXPERTISE FOR THIS COMMITTEE: \_\_\_\_\_

SEND TO: Chairman, Board of Trustees, Illinois State Medical Society  
55 E. Monroe, Suite 3510, Chicago, IL 60603

# ISMS Program Summary

## By Days

### (Preliminary)

All meetings to be held in the Holiday Inn Mart Plaza

#### Friday April 22, 1977

7:00 p.m. IFMC Board Meeting

#### Saturday April 23, 1977

8:30 a.m. Resident Physicians Section  
9:00 a.m. IFMC Adm. Board Meeting  
10:00 a.m. Student Business Session  
12:00 noon ISMS Board Luncheon  
1:30 p.m. ISMS Board Meeting  
5:30 p.m. ISMS Board Reception & Dinner  
7:30 p.m. ISMS Board Meeting

#### Sunday April 24, 1977

7:30 a.m. Illinois Academy Preventive Medicine  
Bfst. Mtg. (Members only)  
8:00 a.m. Registration Opens  
9:00 a.m. IFMC Annual Meeting  
11:00 a.m. District Caucuses  
2:00 p.m. House of Delegates Credentials  
2:30 p.m. House of Delegates  
6:00 p.m. Delegates Buffet  
7:30 p.m. Reference Committees

Constitution & Bylaws  
Committee A Officers, Administration, Finances & Budgets  
Committee B Government Health Programs  
Committee C Education, Manpower & Clinical Medicine  
Committee D Economic Matters Outside of Government  
Programs; Social & Medical Services; Environmental & Community Health  
Committee E Governmental Affairs & Medical Legal

Committee F Public Relations, Membership Services & Miscellaneous Business  
Committee G Unspecified Subject Matter

#### Monday April 25, 1977

7:30 a.m. ISMS Board Breakfast Meeting  
8:00 a.m. Registration Opens  
9:00 a.m. Alcoholism Meeting  
10:00 a.m. ICCME Workshop  
10:00 a.m. IMPAC Workshop  
11:30 a.m. Fifty Year Club Luncheon  
12:00 noon IMPAC Workshop Luncheon  
6:00 p.m. President's Reception & Dinner

#### Tuesday April 26, 1977

7:30 a.m. Public Affairs Breakfast  
8:00 a.m. Registration Opens  
9:00 a.m. ICCME Leadership Workshop  
9:00 a.m. PM&R Meeting  
9:00 a.m. Illinois Society of Pathology Meeting  
10:00 a.m. ISMIE Membership Meeting  
1:00 p.m. House of Delegates Credentials  
2:00 p.m. House of Delegates

#### Wednesday April 27, 1977

7:30 a.m. ISMS Board Breakfast Meeting  
8:00 a.m. Registration Opens  
8:00 a.m. House of Delegates Credentials  
9:00 a.m. House of Delegates  
2:00 p.m. ISMS Board Meeting

### CALLS WILL REACH YOU EASILY AT THE 1977 CONVENTION

Doctor, please inform your staff that while you are attending the ISMS convention, you may be reached through the Physician's Message Center, open April 23-27, 1977 from 9:00 a.m. to 5:00 p.m. Here is the number to remember:

**312-787-3061**

This is a direct connection which will not go through the hotel switchboard.

# ANNUAL MEETING PROGRAM

## ISMS Auxiliary

### (Preliminary)

*The Holiday Inn Mart Plaza is the official hotel for the ISMS Annual Meeting. Most of the ISMS Auxiliary business meetings, however, will be held in the Merchants and Manufacturers Club, on the second floor of the Merchandise Mart (directly across the street from the Holiday Inn). Auxilians are advised to carefully check the location of each designated meeting.*

## Monday, April 25

9:00-5:00	Registration	Holiday Inn, 14th Floor
10:00-3:00	IMPAC/AMPAC Workshop for ISMS and ISMS Auxiliary	Holiday Inn
11:00	Pin and Gavel Gathering	Holiday Inn
3:30	Pre-Convention Board Meeting	Holiday Inn, Shakespeare Room, 14th Floor
6:00	President's Night, Dinner-Dance Featuring the Second City, Reservations required	Holiday Inn, Sauganash Ballroom

## Tuesday, April 26

7:30 a.m.	Public Affairs Breakfast	Holiday Inn, Sauganash Ballroom
8:00-4:00	Registration	Merchandise Mart—second floor
9:30	First Session: ISMS Auxiliary, House of Delegates Welcome & Response: <i>Mrs. Jack Clemis, President CMS Auxiliary</i> <i>Mrs. R. S. Hoover, Convention Chairman, Lake County</i>	Merchandise Mart—second floor
	Pledge	
	Greetings from ISMS Officers	
	Report of Nominating Committee: <i>Mrs. Eugene Vickery, Chairman</i>	
	Report of Budget Committee <i>Mrs. Reuben Gaines, Chairman</i>	
	Nominations for Nominating Committee	
	Nominations for Delegates and Alternates to AMAA	
	Voting by Ballot	
	Memorial Service	
	County Presidents' Reports	
11:30	Hospitality and view of displays	Merchandise Mart—second floor
12:00 noon	ISMS Auxiliary President's Luncheon <i>Speaker: James West, M.D., "The Impaired Physician"</i>	Merchandise Mart—second floor
2:30	Second Session, ISMS Auxiliary House of Delegates Continue County Presidents' Reports	Merchandise Mart—second floor
5:30	Fun & Frolic	Holiday Inn

## Wednesday, April 27

8:00-12:00	Registration	Merchandise Mart—second floor
9:00	Third Session, ISMS Auxiliary House of Delegates Tellers' Report of Election of Nominating Committee Tellers' Report of Election of Delegates & Alternates to AMA Auxiliary Adoption of 1977-78 budget <i>Speaker: George Wilkins, M.D., President-Elect, ISMS</i> <i>Speaker: Mrs. Grace Baysinger, "T.V. Violence"</i> Presentation of Awards: AMA-ERF, Humanitarian, Membership	Merchandise Mart—second floor
12:00 noon	Installation Luncheon	Merchandise Mart—second floor
2:30	Post-Convention Board Meeting and Workshop	Holiday Inn Shakespeare Room

# Agenda

## 1977 House of Delegates

James A. McDonald, M.D., *Speaker*

Cyril C. Wiggishoff, M.D., *Vice Speaker*

### FIRST SESSION

2:30 P.M. Sunday, April 24, 1977

Sauganash Ballroom  
Holiday Inn — Mart Plaza  
Chicago

1. Call to order  
James A. McDonald, M.D., *Speaker*
2. Invocation
3. Report of Committee on Rules and Order of Business  
A. Beaumont Johnson, M.D.  
*Chairman*
4. Report of Credentials Committee  
E. K. DuVivier, M.D. and  
Charles Schlageter, M.D.  
*Co-Chairmen*
5. Approval of the minutes of the previous meeting
6. Memorial service for deceased members since April, 1976, conducted by Jacob E. Reisch, M.D.,  
*Secretary-Treasurer*
7. Reports of Special Guests
  - (a) Mrs. John Ovitz, Jr., *President* Illinois State Medical Society Auxiliary
  - (b) Mrs. Ruby Jackson, *President*, Illinois Society, American Association of Medical Assistants
8. Introduction of special guests
9. Presentation of Continuing Medical Education Awards
10. Presentation of AMA-ERF check to Illinois Medical Schools
11. IMPAC Report  
Mrs. Pam Taylor
12. Illinois Foundation for Medical Care Report  
Allan L. Goslin, M.D.
13. Report of Executive Administrator  
Roger N. White
14. Introduction of AMA Delegates and Alternate Delegates  
Jack L. Gibbs, M.D.
15. The President's Address  
Joseph Skom, M.D.
16. Remarks of Speaker
17. Resolutions and Supplementary Reports
18. New Business and Announcements  
Delegates Buffet—6:00 p.m.  
Reference Committees—7:30 p.m.
19. Recess until 2:00 p.m. Tuesday, April 26, 1977

### SECOND SESSION

2:00 P.M. Tuesday, April 26, 1977

Sauganash Ballroom  
Holiday Inn — Mart Plaza  
Chicago

1. Call to order by the speaker
2. Invocation
3. Report of Committee on Rules and Order of Business
4. Report of Credentials Committee
5. Announcements and Introduction of guests
6. Reports of Reference Committees  
Amendments to Constitution & Bylaws
  - A. Reports of Officers, Administration, Finances and Budgets
  - B. Government Health Programs
  - C. Education, Manpower, & Clinical Medicine
  - D. Economic Matters Outside of Government Programs; Social & Medical Services; Environmental & Community Health
  - E. Governmental Affairs & Medical Legal
  - F. Public Relations, Membership and Miscellaneous Business
  - G. Unspecified Subject Matter
7. Unfinished business
8. New business
9. Recess until 9:00 a.m. Wednesday, April 27, 1977



### THIRD SESSION

9:00 A.M. Wednesday, April 27, 1977

Sauganash Ballroom

Holiday Inn — Mart Plaza

Chicago

1. Call to order by the speaker
2. Invocation
3. Report of Committee on Rules and Order of Business
4. Report of Credentials Committee
5. Induction of George Wilkins, M.D., *President-Elect*,  
into office of President by Joseph Skom, M.D.
6. Address of President Wilkins
7. Announcements and introduction of special guests
8. Reports of Reference Committees
9. Elections
  - Report of Nominating Committee
    - (a) President-Elect (CMS)
    - (b) 1st Vice President (DS)
    - (c) 2nd Vice President (CMS)
    - (d) Secretary-Treasurer (DS)
    - (e) Speaker of the House (CMS)
    - (f) Vice Speaker (DS)
    - (g) Trustees
  - District*
    - First District Joseph L. Bordenave
    - Second District Allan L. Goslin
    - 3rd District William M. Lees
    - 3rd District Joseph C. Sherrick
    - 3rd District Alfred Faber
    - 3rd District Phillip G. Thomsen
    - Eleventh District Ross Hutchison
    - (12) 1A District P. John Seward
  - Terms Expiring*
    - Robert R. Hartman
    - J. M. Ingalls (resigned)
    - E. P. Johnson
    - Joseph B. Moles
    - George Shropshire (resigned)
    - Glen E. Tomlinson
    - George T. Wilkins
- (h) Delegates to AMA to take office Jan. 1, 1978,  
and serve until Dec. 31, 1979
  - Terms Expiring*
    - Howard C. Burkhead
    - Herschel L. Browns
    - Jack L. Gibbs
    - Theodore Grevas
    - Morgan M. Meyer
    - Edward A. Piszczek
    - Fred A. Tworoger
- (i) Alternate Delegates to AMA to take office  
Jan. 1, 1978, and serve until Dec. 31, 1979
  - Terms Expiring*
    - Robert R. Hartman
    - J. M. Ingalls (resigned)
    - E. P. Johnson
    - Joseph B. Moles
    - George Shropshire (resigned)
    - Glen E. Tomlinson
    - George T. Wilkins
10. Fixing of per capita dues for 1978
11. Selection of meeting place and time for next annual  
meeting
12. Unfinished business
13. New business
14. Adjournment, sine die

### *Clinical Symposia* *Tuesday, April 26, 1977*

#### **Illinois Society Physical Medicine & Rehabilitation** **"Evaluation & Treatment"**

9:00 a.m.

Moderator: Padma Sundaram, M.D., Rush School of Medicine, Chicago  
Participants: *Eleanor Boder, M.D., Daniel Halpern, M.D., J. G. Millichap, M.D.*

Regular meeting of the Illinois Society of Physical Medicine  
and Rehabilitation, 12:30 p.m.



#### **Illinois Society of Pathologists** **"Surgical Pathology Problem Cases"**

9:00 a.m.

Moderator: Paul B. Szanto, M.D., Director of Pathology, Hektoen  
Institute for Medical Research of Cook County Hospital, Chicago  
Participants and Members of the Illinois Tumor Registry:

*Hector Battifora, M.D., Victor Gould, M.D., Albert I. Rubenstone, M.D.*  
*William Thomas Jr., M.D., Raoul Fresco, M.D., Martin Sverdlow, M.D.*  
*Gertrude Novak, M.D., Jonas Valaitis, M.D., Balbino Fernandez, M.D.*  
*Yolanda Trijillo, M.D.*

Luncheon, Illinois Society of Pathologists, 12:30 p.m.

# Committees of the House of Delegates

## 1977 Annual Meeting

### COMMITTEE ON RULES & ORDER OF BUSINESS

A. Beaumont Johnson, *Chairman* (DS)

Vincent A. Costanzo (CMS) Herbert V. Fine (DS)

Eugene Pitts (DS) Charles J. Weigel (CMS)

This committee shall consider all matters regarding rules governing actions, methods and procedure, and the order of business (agenda) for the session of the House of Delegates. It shall work in close cooperation with the Speaker and Vice Speaker.

The committee shall contact the Speaker just prior to each session of the House to make sure that all recommendations for House action are included in its report.

### COMMITTEE ON CREDENTIALS

Edward K. DuVivier, *Co-Chairman* (DS)

Charles W. Schlageter, *Co-Chairman* (CMS)

George Gertz (CMS) Vincent C. Freda (CMS)

William C. Perkins (DS)

This committee shall consider all questions regarding the registration and certification of delegates. The chairman shall keep the Speaker of the House informed of the voting power thereof.

The committee shall distribute and receive the attendance slips and perform such other duties as may be assigned by the Speaker.

This committee shall meet at least one hour prior to the opening session of the House and one-half hour prior to the opening of the other sessions.

### TELLERS AND SERGEANTS AT ARMS

Anna Marcus, *Chief Teller* (CMS)

William O. Ackley (CMS) Carl F. Palumbo (CMS)

Humberto Mondul (DS) Donald H. Rames (DS)

This committee shall serve the Speaker of the House of Delegates whenever a vote count is called for, whenever a ballot is scheduled, or the House goes into executive session.

### REFERENCE COMMITTEE ON AMENDMENTS TO CONSTITUTION & BYLAWS

John Hyde, *Chairman* (CMS)

Edward G. Ference (DS) Paul P. Lorenz (DS)

Rocco V. Lobraico, Jr., (CMS) Edward A. Razim (CMS)

*Standby:* Arthur Peterson (CMS)

Ernest F. Adams (DS)

*STAFF:* Perry Smithers and Gloria Evans

This committee shall consider and report to the House of Delegates its recommendations on all proposed amendments to the Constitution and Bylaws.

### REFERENCE COMMITTEE A

Burton Sobroff, *Chairman* (CMS)

Samuel Andelman (CMS) Merle L. Otto (DS)

John Kozak (CMS) Donald D. Tomlin (DS)

*Standby:* Robert F. Hamilton (DS)

Lydia Walkowiak (CMS)

*STAFF:* James Slawny, and Roseanne Christiansen

This committee shall consider and submit its recommendations to the House of Delegates upon the resolutions and reports of:

Officers  
Administration  
Finances  
Budgets

### REFERENCE COMMITTEE B

Harold J. Lasky, *Chairman* (CMS)

Richard Blankshain (CMS) John L. Hubbard (DS)

E. J. Fesco (DS) Jesse Walley (CMS)

*Standby:* Joseph Hinkamp (CMS)

Lee Johnson (DS)

*STAFF:* Al Lerner and Sylvia Fischer

This committee shall consider and submit its recommendations to the House of Delegates upon resolutions and reports relating to government health programs.

### REFERENCE COMMITTEE C

F. H. Riordan, *Chairman* (DS)

Charles F. Eddingfield (DS) Meredith B. Murray (CMS)

Alex Kaz (CMS) O. W. Pfisterer (DS)

*Standby:* Robert Barnes (DS)

*STAFF:* Dick Ott and Alice Underwood

This committee shall consider and submit its recommendations to the House of Delegates upon reports relating to education, manpower and clinical medicine.

## REFERENCE COMMITTEE D

Charles A. DeKovessey, *Chairman* (DS)  
E. C. Bone (DS) William B. Frymark (DS)  
Edwin Falloon (CMS) M. Barry Kirschenbaum (CMS)  
*Standby:* James P. FitzGibbons (CMS)  
Frank Kresca (DS)

**STAFF:** Larry Boress and Betty Kararo

This committee shall consider and submit its recommendations to the House of Delegates upon resolutions and reports on all economic matters outside government programs, social and medical services, environmental and community health.

## REFERENCE COMMITTEE E

Robert Hamilton, *Chairman* (CMS)  
Raymond DesRosiers (CMS) Kenneth Hurst (DS)  
John Harrod (CMS) Harold J. Kolb (DS)  
*Standby:* Charles R. Frazer, Jr. (DS)  
Frank Kwinn (CMS)

**STAFF:** Don Udstuen and Linda Forestor

This committee shall consider and submit its recommendations to the House of Delegates upon reports relating to governmental affairs and medical-legal.

## REFERENCE COMMITTEE F

Loren Boon, *Chairman* (DS)  
George Shimkus (DS) David Petty (CMS)  
Severo Guerrero (CMS) John P. Pope (DS)  
*Standby:* Jere Freidheim (CMS)  
**STAFF:** Ned Stuppy and Mary Szymanski

This committee shall consider and submit its recommendations to the House of Delegates upon resolutions and reports relating to public relations, membership services and miscellaneous business.

## REFERENCE COMMITTEE G

Robert A. Behmer, *Chairman* (DS)  
Richard Arnell (DS) Martin Meisenheimer (CMS)  
Arthur Kunis (CMS) August Rosetti (DS)  
*Standby:* Gene O. Hoerr (DS)  
James O'Brien (CMS)  
**STAFF:** Dick Hengl

This committee shall consider and submit its recommendations to the House of Delegates upon the reports and resolutions on unspecified subject matter referred to it by the Speaker.

---

## *Schedule of Meetings*

### *Monday, April 25, 1977*

- Illinois Council for Continuing Medical Education
  - Workshop for Those Seeking Accreditation 10:00 a.m.
  - Workshop on CME Planning in Accredited Institutions 10:00 a.m.
  - Annual Meeting of CME Accreditation Examiners 1:30 p.m.
- ISMS Committee on Emergency and Disaster Care, in Conjunction with the Chicago Hospital Council
  - "The Alcoholic in the Emergency Room" 9:00 a.m.
- IMPAC-AMPAC Workshop
  - "Practical Politics—The How and Why" 10:00 a.m.



### *Tuesday, April 26, 1977*

- Public Affairs Breakfast 7:30 a.m.
- Illinois Council for Continuing Medical Education
  - Workshop on CME Leadership 9:00 a.m.
- Illinois State Medical Inter-Insurance Exchange
  - Annual Membership Meeting 10:00 a.m.

# Resolutions

## Resolution 77A-1

Introduced by: Paul M. Stromborg, M.D., Intern-Resident Delegate  
Subject: Amendment to Chapter IV, Section 11, of the Bylaws  
Referred to: Reference Committee on Amendments to Constitution and Bylaws

WHEREAS, The Resident Physician Section has been established as the official body representing house-staff; and

WHEREAS, The Annual meeting of the RPS will be the day prior to the annual ISMS House of Delegates meeting; and

WHEREAS, Any resolutions introduced at the RPS meeting must, by definition, be late resolutions, and as such suffer possible rejection under current bylaws; and

WHEREAS, The AMA has modified its bylaws to allow resident physicians and medical students to introduce late resolutions without review by the late resolution committee, therefore be it

RESOLVED, That the ISMS Bylaws Chapter IV, Section 11 be amended as follows:

All resolutions must be introduced by a voting member of the House. Resolutions to be printed in the handbook must be submitted nine weeks prior to the annual meeting. Resolutions to be mailed to the delegates prior to the annual meeting must be submitted to ISMS headquarters four weeks prior to the annual meeting. *Resolutions presented from the Business Meeting of the Resident Physicians Section or the Student Business Session may be presented for consideration by the House of Delegates at any time before the close of business of the first day session of the House of Delegates.* Resolutions submitted after the above date, *except those originating from the RPS or SBS Business Sessions*, must be approved by Speaker, Vice Speaker, . . .

## Resolution 77A-2

Introduced by: Charles J. Jannings, III, M.D. for the Wayne County Medical Society  
Subject: Generic Labeling for Drugs Crossing International Borders  
Referred to: Reference Committee D

WHEREAS, Restrictive policies on the part of the U.S. Food and Drug Administration have progressively widened the gap between new drugs available in the United States and in most other nations; and

WHEREAS, Patients are becoming increasingly more sophisticated and aware of this differential; and

WHEREAS, It is often in the best interest of the patient to obtain from a foreign source drugs which are not available in the United States; and

WHEREAS, United States citizens are more frequently obtaining such medication; and

WHEREAS, Many of these individuals are concurrently under the care of their local family physician; and

WHEREAS, The local family physician has a need to know the chemical ingredients of the drugs which his patients obtain from foreign sources; and

WHEREAS, This presents a dilemma for the family physician and may also place the health of the patient in jeopardy; therefore be it

RESOLVED, That the Illinois State Medical Society petition the American Medical Association, through its delegates to the World Health Organization and our United Nations Representative, to require generic labeling on all drugs transported by patients across international borders and that border inspectors be required to honor this request by international agreement.

## Resolution 77A-3

Introduced by: George Lagorio, M.D.  
Subject: Public Aid Resolution  
Referred to: Reference Committee B

WHEREAS, The public aid situation in the State of Illinois has deteriorated into chaos; and

WHEREAS, Dr. Carell Hutchinson, Dr. Finley Brown, Dr. George Lagorio and attorney Mr. Roger Gold requested permission of the Illinois State Medical Society and Chicago Medical Society to write a series of articles which would consist of the following:

1. The deteriorating public aid situation in Illinois.
2. The problems within the Illinois Department of Public Aid itself.
3. Factoring companies.
4. How to prepare for medical audits from the Illinois Department of Public Aid.
5. Possible solutions to the problems; and

WHEREAS, The above articles would be beneficial to all members of the Illinois State Medical Society; therefore be it

RESOLVED, That the House of Delegates instruct the leadership of the Illinois State Medical Society to allow articles entitled, "The Deteriorating Public Aid Situation in Illinois;" "The Problems within the Illinois Department of Public Aid Itself;" "Factoring Companies;" "How to Prepare for Medical Audits from the Illinois Department of Public Aid," and "Possible Solutions to Problems with Public Aid" to be published in the *Illinois Medical Journal* in the near future.

## Resolution 77A-4

Introduced by: George Lagorio, M.D.  
Subject: Advertising  
Referred to: Reference Committee B

WHEREAS, On numerous occasions Dr. Lagorio has attempted to run advertisements in the Illinois State Medical Society Journal and in Chicago Medicine; and WHEREAS, The advertisements, always in good taste, have been refused publication; and

WHEREAS, These advertisements are of great importance to the practicing physician in the State of Illinois; and

WHEREAS, An example of one of the advertisements is as follows:

### DOCTOR

Are you having problems with the Illinois Department of Public Aid?

To solve your problem, call Dr. George Lagorio now. Area Code: 312/782-7281, Room 720, 39 S. LaSalle St., Chicago, Ill. 60603.



therefore be it

RESOLVED, That the Illinois State Medical Society House of Delegates instruct its leadership to allow advertisements concerning Public Aid problems to be printed in the appropriate medical society publications with the same restrictions as those of other advertisers.

#### Resolution 77A-5

Introduced by: George Lagorio, M.D.

Subject: The Illinois Department of Public Aid Negotiating Resolution

Referred to: Reference Committee B

WHEREAS, The House of Delegates of the Illinois State Medical Society directed the Illinois Foundation for Medical Care to become the negotiating unit with the Illinois Department of Public Aid; and

WHEREAS, The Illinois Foundation for Medical Care has abdicated this role and has not been able to carry out the directives of the Illinois State Medical Society House of Delegates; and

WHEREAS, The committee which is now dealing with the Illinois Department of Public Aid is the Governmental Health Program Reimbursement Committee, which historically has not been able to do anything in solving the problems of physicians with the Illinois Department of Public Aid; therefore be it

RESOLVED, That an ad hoc committee be established to study the possibility of developing an organization with the necessary experience and strength to represent physicians who render care to public aid recipients with the Illinois Department of Public Aid; and be it further

RESOLVED, That this organization be so constructed that its actions will in no way place the Illinois State Medical Society in jeopardy of violating the Sherman anti-trust laws or of losing its charter and tax-exempt status.

#### Resolution 77A-6

Introduced by: George Lagorio, M.D.

Subject: New Patient Limited Service (Code 90010)

Referred to: Reference Committee B

WHEREAS, The Current Procedural Terminology manual of the AMA defines Code 90010 as "limited examination, evaluation or treatment (of new patient); a service constituting a brief or interval history of the complaint, illness or course, limited examination and discussion of findings."

"Limited: a level of services requiring limited effort or judgment, such as abbreviated or interval history, limited examination or discussion of findings and/or treatment.

For example: (a) review of interval history, blood sugar and medication by physician on stable diabetic. (b) review of interval history, determination of blood pressure, auscultation of the heart and adjustment of medication in a patient with compensated arteriosclerotic heart disease on anticoagulant therapy.

(c) review of recent history, determination of blood pressure, auscultation of the heart and adjustment of medication in stable essential hypertension;" and

WHEREAS, The Physicians Handbook of the Illinois Department of Public Aid defines the above code

as follows:

"Initial visit, new patient—the first visit of a new patient whom the physician or any other physician in the same group or office has not seen before. The visit includes a limited history, a limited physical examination to the extent necessary to arrive at a provisional diagnosis, and a medical evaluation in response to presenting complaints and symptoms. Treatment is initiated and medical advice and direction given.

"This type of visit is allowed only one time by a physician for an individual patient. In partnerships or group practices, it is allowed only one time collectively for all physicians in the group who eventually may see the recipient.

"Medical record documentation required—in addition to the symptoms and complaints, a limited past history; a statement of onset and course of the present condition; the physical examination findings; the laboratory and x-ray procedures ordered and their results; the provisional diagnosis; treatment given or recommended; and follow-up advice given should be listed as outlined for a comprehensive diagnostic visit;" and

WHEREAS, The Department of Computer Systems in Medicine of the AMA has reviewed the above definitions and finds that there does not exist a one to one correspondence between the office visit and procedure code contained in the two publications; and

WHEREAS, It is apparent from the above that most physicians practice medicine in compliance with the CPT; and

WHEREAS, It is virtually impossible for any physician in the State of Illinois to comply strictly to the documentation required in the Physicians Handbook of the Illinois Department of Public Aid; therefore be it

RESOLVED, That the House of Delegates of the Illinois State Medical Society reject the code definition for new patient limited services in the Physicians Handbook of the IDPA until it is brought into compliance with the Current Procedural Terminology manual of the AMA, Edition IV; and be it further

RESOLVED, That the House of Delegates direct the leadership of ISMS to directly advise the members to continue to practice and deliver care according to the code definition in the CPT, Edition IV.

#### Resolution 77A-7

Introduced by: George Lagorio, M.D.

Subject: Routine Office Visit (Code 90040)

Referred to: Reference Committee B

WHEREAS, The Current Procedural Terminology of the AMA defines Code 90040 as a brief visit on an established patient as "brief: a level of service requiring a brief period of time with minimal effort or judgment by the physician. For example, (a) re-examination of mononeuritis, (b) examination of conjunctiva by the physician in a patient with sub-conjunctival hemorrhage, and (c) throat examination for active tonsillitis;" and

WHEREAS, The Physicians Handbook of the Illinois Department of Public Aid defines the procedure as follows:

"Routine Visit—the most common type visit. Return visit of an established patient for examination and treatment by the physician of new complaints and symptoms or for re-check by the physician of the

previous condition and response to continuing treatment.

Medical record documentation required—symptoms or complaints (or changes therein); the onset, duration, and course of illness; history of past similar conditions and past individual history, as pertinent (allergies, etc.); physical examination findings relating to the affected area; the diagnostic procedures ordered and their results; provisional diagnosis; treatment given or recommended and advice given should be listed as outlined for a comprehensive diagnostic visit.

Procedure Code 90040 is to be used to identify charges for this type of visit;”

WHEREAS, It is obvious that there is a tremendous disparity between the definition for this visit in the two publications mentioned above; therefore be it

RESOLVED, That the House of Delegates of the Illinois State Medical Society reject the definition of the brief visit on an established patient, Code 90040 in the Physicians Handbook of IDPA, until it is brought into compliance with the Current Procedural Terminology of the AMA, Edition IV; and be it further

RESOLVED, That the House of Delegates direct the Illinois State Medical Society leadership to offer the Illinois Department of Public Aid whatever assistance is necessary to bring the two publications into compliance; and be it further

RESOLVED, That the House of Delegates direct the leadership of ISMS to directly advise the members to continue to practice and deliver care according to the code definition in the CPT, Edition IV.

#### **Resolution 77A-8**

Introduced by: George Lagorio, M.D.

Subject: Comprehensive Diagnostic Visit (Code 90020)

Referred to: Reference Committee B

WHEREAS, The Current Procedural Terminology manual of the AMA defines Code 90020 as a comprehensive adult service as defined as follows:

“Comprehensive: a level of service providing an in-depth evaluation of the patient.

“For example, (a) evaluation of the patient including complete history, physical examination and initiation of diagnostic and/or treatment program, (b) re-examination or re-evaluation of patient with continuing or new illness, including complete history, physical examination and the initiation of diagnostic and/or treatment program;” and

WHEREAS, The Physicians Handbook of the Illinois Department of Public Aid defines comprehensive diagnostic visit as:

“Comprehensive Diagnostic Visit—Because of the time element involved in the complexity of the examination, this is the least common type of office examination. It includes complete personal, family, allergy and immunization history, thorough system review and physical examination, medical evaluation and diagnosis by physician, discussion of condition with patient, initiation of treatment program, immediate and projected, and giving of medical advice and direction to the recipient and family, as appropriate. “Medical documentation required—presenting symptoms and complaint, family history (mother, father, etc.), individual past history, illnesses, surgery, accidents, etc., allergies, sensitivities, immunizations,

psychiatric conditions, habits (smoking, alcohol, drugs, etc.), weight gains or losses; onset and course of present illness, including previous episodes; review of systems, including past conditions; physical examination findings, including unrelated abnormal findings as well as those pertinent to present illness; investigative procedures such as laboratory and x-ray examinations, listing of all diagnostic procedures ordered, when, where and reports of findings of each; copy of any consultation reports requested; provisional diagnosis or problem oriented impression, including other possible diagnoses, if appropriate; treatment record, injections given (what, amount, etc.); medications prescribed or dispensed (what, amount, dosage, etc.); any other medical treatment given; surgical treatment given or recommended; recommendation for follow-up or subsequent treatment; other details and specifics as the condition of the recipient may require.

“Procedure Code 90020 is to be used to identify charges for this type visit;” and

WHEREAS, It is obvious that there is tremendous disparity between the definition for this visit in the two publications mentioned above; therefore be it

RESOLVED, That the House of Delegates of the Illinois State Medical Society reject the definition of the diagnostic visit, Code 90020 in the Physicians Handbook of IDPA, until it is brought into compliance with the Current Procedural Terminology of the AMA, Edition IV; and be it further

RESOLVED, That the House of Delegates direct the Illinois State Medical Society leadership to offer the Illinois Department of Public Aid whatever assistance is necessary to bring the two publications into compliance; and be it further

RESOLVED, That the House of Delegates direct the leadership of ISMS to directly advise the members to continue to practice and deliver care according to the code definition in the CPT, Edition IV.

#### **Resolution 77A-9**

Introduced by: E. C. Bone, M.D., for the Morgan-Scott County Medical Society

Subject: Preservation of Health Care System Through Private Enterprise

Referred to: Reference Committee D

WHEREAS, There is an ever-present escalation in the cost of living for the people of these United States; and

WHEREAS, The cost to the people for products and services required to treat medical illnesses escalates proportionally with the national cost of living; and

WHEREAS, The great majority of persons prefer to pay for the products consumed and services rendered in treatment of their medical illnesses; and

WHEREAS, The political climate of the Ninety-third Congress and its immediate successors promises to have appropriate chemistries to formulate and pass legislation supportive of nationalized health insurance; and

WHEREAS, President Carter has included in his campaign promises, and plans for action subsequent to election, to give high priority to national health insurance; and

WHEREAS, The members of the medical profession have compassion for the sick and desire to render

the best possible care for their patients; and

WHEREAS, Some patients do not present themselves for health care feeling that identification of their medical problems and the establishment of a regimen for medical management will result in insurmountable financial burden; therefore be it

RESOLVED, That the House of Delegates of the Illinois State Medical Society approve the establishment of an ad hoc committee to study the health care system of Illinois and to develop a plan for preserving it through private enterprise; and be it further

RESOLVED, That the committee include representatives from ISMS membership, the private insurance industry, Illinois Bankers Association, Illinois Bar Association and such other representatives as will implement the final product; and be it further

RESOLVED, That this concept be given high priority for immediate implementation by the Illinois State Medical Society; and be it further

RESOLVED, That the AMA be fully informed of the plans and progress of this committee and asked for supportive liaison representation to this committee.

#### **Resolution 77A-10**

Introduced by: George Lagorio, M.D.

Subject: Record Requirements

Referred to: Reference Committee B

WHEREAS, Section A-206 of the Illinois Department of Public Aid Handbook for Physicians states:

"Record Requirements. Physicians must maintain office medical records for each recipient patient. In group practices, partnerships, and other shared practices, one record is to be kept with chronological entries by the specific physician rendering service. Basically, the record is to include the essential details of the recipient health condition and of each service provided. All entries must be dated and legible.

"Minimal record requirements satisfying Department standards for the various types of office visits to be found in Topic A-220;" and

WHEREAS, It is almost impossible for any physician at any one time, to document findings at this maximal level; and

WHEREAS, It is not necessary to have this maximal documentation to justify the type of health care delivered to a patient under appropriate peer review; therefore be it

RESOLVED, That the House of Delegates of the Illinois State Medical Society reject the minimal records requirements established by the Illinois Department of Public Aid as being unrealistic and grossly unfair to physicians who deliver health care to public aid recipients; and be it further

RESOLVED, That the House of Delegates of the Illinois State Medical Society request and demand that the Illinois Department of Public Aid bring its medical record requirements into compliance with the definitions as contained in the Current Procedural Terminology manual of the AMA, Edition IV; and be it further

RESOLVED, That the definitions and minimal record requirements, as outlined in the Physicians Handbook of the IDPA, be rejected code number by code number until they are brought into compliance with accepted medical practice in the State of Illinois; and

be it further

RESOLVED, That ISMS instruct physicians to continue to render care to public aid recipients according to the definitions in CPT, Edition IV.

#### **Resolution 77A-11**

Introduced by: George Lagorio, M.D.

Subject: Level of Care

Referred to: Reference Committee B

WHEREAS, The Physicians Handbook of the Illinois Department of Public Aid, Section A-203, Covered Services, states:

"A covered service is a service for which payment can be made by the Department. Covered are those reasonable, necessary medical and remedial services which are recognized as standard medical care because of illness, disability, infirmity, or impairment, and which are necessary for immediate health and well-being;" and

WHEREAS, Section A-204 states services not covered:

"Services for which medical necessity is not clearly established are not covered in the Medical Assistance Program. Additionally, the following services are specifically excluded from coverage and payment cannot be made by the Department for the provision of these services: (a) Preventive services, (b) Routine physical examination, (c) Examination requiring determination of disability or incapacity, (d) Experimental or surgical services, (e) Acupuncture, (f) Investigational and research oriented procedures, (g) Artificial insemination, (h) Trans-sexual surgery, (i) Services prohibited by Illinois or federal statutes, (j) Services provided in federal or state institutions, (k) Medical care provided by mail or telephone, (l) Unkept appointments, (m) Autopsy examinations, (n) Subsequent treatment for venereal disease when such services are available through state and/or local health agencies, (o) Visits with persons other than a recipient, such as family members or group care facility staff, (p) Preparation of records, forms and reports, (q) Diagnostic and/or therapeutic procedures related to primary infertility and sterility, and (r) Cosmetic procedures, medical or surgical, where projected results do not relieve a physical or functional handicap;" and

WHEREAS, It is obvious from the above statement that the level of care delivered to a public aid recipient is at a level below the standard that is delivered to the majority of patients in this nation; and

WHEREAS, This dual system of health care delivery is objectionable to all practicing physicians; therefore be it

RESOLVED, That the House of Delegates of the Illinois State Medical Society adopt the policy that the level of care and opportunity to receive care by public aid recipients be the same as that of all other patients in this nation; and be it further

RESOLVED, That the House of Delegates of the Illinois State Medical Society reject this dual level of health care delivery; and be it further

RESOLVED, That the House of Delegates of the Illinois State Medical Society work for the development of a unified health care delivery system that would be appropriate for all citizens in the State of Illinois.



### Resolution 77A-12

Introduced by: George Lagorio, M.D.

Subject: Current Procedural Terminology Manual—Illinois Department of Public Aid Handbook Discrepancy

Referred to: Reference Committee B

WHEREAS, The February 14, 1977, issue of the Illinois State Medical Society Action Report stated that important concessions were obtained from the Illinois Department of Public Aid; and

WHEREAS, The problem with the procedure codes was not the numbers used but the difference in definitions; and

WHEREAS, This continued lack of correspondence in the definitions in the Current Procedural Terminology and the Physicians Handbook is unworkable; therefore be it

RESOLVED, That the Illinois Department of Public Aid definition of procedure codes be brought into compliance with the Current Procedural Terminology of the AMA; and be it further

RESOLVED, That the Illinois State Medical Society direct its members to continue to render care according to the definitions in the Current Procedural Terminology of the AMA.

### Resolution 77A-13

Introduced by: George Lagorio, M.D.

Subject: Illinois Department of Public Aid's Two-Faced Approach to Physician-Providers

Referred to: Reference Committee B

WHEREAS, The Illinois Department of Public Aid has recently stated that the IDPA Informational Material for Physicians (dated 8/12/69) informed all physicians participating in the Medicaid Program that surgical and medical procedures being charged must be coded according to the AMA Current Procedural Terminology second edition; and

WHEREAS, The above mentioned informational pack was not made available to physicians even on request and was received by only a few; and

WHEREAS, The fault in not disseminating the rules and regulations that physicians should work under in relation to the Illinois Department of Public Aid lies with the Illinois Department of Public Aid and not the physician; and

WHEREAS, Physicians were given verbal instructions contrary to those contained in the Current Procedural Terminology of the AMA by knowledgeable personnel of the Illinois Department of Public Aid; and

WHEREAS, The physician who followed the apparent and trustworthy verbal instructions of personnel in the Illinois Department of Public Aid is now being forced to pay back large sums of money based on computer audits and field audits; therefore be it

RESOLVED, That the House of Delegates of the Illinois State Medical Society condemn the Illinois Department of Public Aid for unfairly blaming physicians for accepting reimbursement in amounts which IDPA now claims were too high when the blame for inaccuracies should properly have been with IDPA, which did not issue adequate instructions or regulations; and be it further

RESOLVED, That this issue be carried to its ultimate conclusion which would result in clearing the image of medicine in the State of Illinois from abuse of the Medicaid Program and place the blame for abuse of the Medicaid Program directly with the Illinois Department of Public Aid.

### Resolution 77A-14

Introduced by: George Lagorio, M.D.

Subject: Illinois Department of Public Aid Abuse of Power

Referred to: Reference Committee B

WHEREAS, Code 90010 in 1969-1970, 1971, 1972 and 1973 was defined as "Office Diagnostic" on the face of DPA form 132 and defined as "90010-Office Diagnostic—means office visit new patient, history and physical examination including initiation of diagnostic and treatment program" on back of DPA form 132; and

WHEREAS, Code 90010 in 1973 was changed and defined as "Office Diagnostic—new patient" on face of DPA form 132 and defined as "90010—Office Diagnostic means office visit, new patient, history and physical examination, including initiation of diagnostic and treatment program" on back of DPA form 132; and

WHEREAS, Physicians were told to treat each new illness as a visit of a new patient for purposes of billing the Illinois Department of Public Aid from 1969-1973; and

WHEREAS, Statements supporting the validity of these occurrences can be obtained from physicians and employees of the Illinois Department of Public Aid; and

WHEREAS, There never was given to physician-providers a written statement to the effect that the definition of 90010 was to be strictly enforced until the Physicians Handbook was related January 1, 1976; and

WHEREAS, The strict interpretation of Code 90010 is being used in retrospective audits covering 1973, 1974, 1975 and 1976; therefore be it

RESOLVED, That the House of Delegates condemn as unfair the unilateral change in policy which the Illinois Department of Public Aid has implemented without any notice being given to the physician-provider as to the intent of strict interpretation of Code 90010; and be it further

RESOLVED, That the Illinois State Medical Society condemn the poor show of faith and lack of courtesy shown physicians in the state by the Illinois Department of Public Aid in this action; and be it further

RESOLVED, That the Illinois State Medical Society initiate or support legal action to prevent the continued rape of the medical profession delivering care to welfare recipients by the Illinois Department of Public Aid.

### Resolution 77A-15

Introduced by: George Lagorio, M.D.

Subject: Unfairness of the Illinois Department of Public Aid

Referred to: Reference Committee B

WHEREAS, The Physicians Handbook of the Illinois Department of Public Aid was released on January 1, 1976, with instructions concerning the rules and regulations under which physicians should furnish in rela-



tion to the Medicaid patient and the Illinois Department of Public Aid; and

WHEREAS, These rules and regulations are now being used for retrospective audits of 1973, 1974, 1975 during which time these rules and regulations were not easily available; and

WHEREAS, When the Pharmacy Handbook came out in June of 1976, it was not to go into effect until January 1, 1977, so that pharmacists and their employees could become aware of its rules and regulations; and

WHEREAS, This courtesy should have been equally shown to physician-providers of Medicaid recipients; therefore be it

RESOLVED, That the manner in which the Physicians Handbook was released by the Illinois Department of Public Aid be condemned as grossly unfair to the physician-provider in the State of Illinois; and be it further

RESOLVED, That in the future no changes be made in the rules and regulations without sixty days notice, in which the physician-provider would have a chance to review, study and comment on the proposed changes before implementation.

#### **Resolution 77A-16**

Introduced by: George Lagorio, M.D.

Subject: "Is This Progress?"

Referred to: Reference Committee B

WHEREAS, The Illinois State Medical Society leadership met with the State Medical Advisory Committee of the Illinois Department of Public Aid to voice objection to part of the Physicians Handbook issued by IDPA; and

WHEREAS, The leadership of ISMS stated in Action Report that the Illinois Department of Public Aid yielded on key Medicaid issues; and

WHEREAS, A close reading of the issues upon which progress was supposedly made reveals that no real progress was made except for the development of an acceptable release of information form and the delay of implementation of the six-month time limit for submission of bills; and

WHEREAS, The supposed progress on (1) fiscal audits, (2) laboratory audits, (3) quality of care audits, and (4) code definition problem in Physicians Handbook of IDPA was no progress at all, but rather capitulation to the position of the IDPA; therefore be it

RESOLVED, That the House of Delegates of the Illinois State Medical Society direct the ISMS leadership to advise physicians to seek legal counsel prior to submission to the audits by IDPA; and be it further

RESOLVED, That members be directed not to release information on private patients without proper authorization; and be it further

RESOLVED, That members be advised not to release information on public aid patients without proper authorization; and be it further

RESOLVED, That members be advised to continue to follow the definition of Current Procedural Terminology of the AMA until the Physicians Handbook of IDPA is brought into compliance with it; and be it further

RESOLVED, That the Illinois State Medical Society initiate and support legal action aimed at bringing these issues to a meaningful resolution for physician-providers.

#### **Resolution 77A-17**

Introduced by: George Lagorio, M.D.

Subject: Conflict of Interest

Referred to: Reference Committee B

WHEREAS, The Illinois State Medical Society should represent the medical profession and physicians; and

WHEREAS, The Governmental Health Program Reimbursement Committee of the Illinois State Medical Society is supposed to represent physicians who have problems with the Illinois Department of Public Aid; and

WHEREAS, The State Medical Advisory Committee of the Illinois Department of Public Aid is appointed by the Director of IDPA in an advisory capacity; and

WHEREAS, When a committee member serves two masters, there is reasonable doubt, at times, who is receiving the better service; and

WHEREAS, Dr. Robert Hartman is chairman of the Governmental Health Program Reimbursement Committee and also a member of the State Medical Advisory Committee of the Illinois Department of Public Aid; and

WHEREAS, This apparent conflict of interest makes it difficult for physicians to bring problems to his committee and to know if his decisions are unbiased because of his affiliation with the State Medical Advisory Committee of the Illinois Department of Public Aid; therefore be it

RESOLVED, That Dr. Robert Hartman be replaced as a member of the Governmental Health Program Reimbursement Committee; and be it further

RESOLVED, That any member of that committee who has served on the State Medical Advisory Committee of the Illinois Department of Public Aid in the past be replaced; and be it further

RESOLVED, That in the future, all appointees to committees be carefully screened so that this embarrassing situation will not occur again; and be it further

RESOLVED, That when a physician is recommended for appointment to a committee outside of the Illinois State Medical Society structure, he not be an elected officer or past elected officer of ISMS, without first relinquishing any appointed office within the society that he might hold or have influence over.

#### **Resolution 77A-18**

Introduced by: Joseph R. O'Donnell, M.D., for the DuPage County Medical Society

Subject: Posting of Prices of Hospital Services, Supplies and Drugs

Referred to: Reference Committee D

WHEREAS, Federal legislation in recent years, (viz. PSRO and P.L. 93-641 HSA) is admittedly geared for cost containment; and

WHEREAS, The physician has been defined as the patient's agent as a supplier of services, and a buyer of ancillary services, and makes decisions affecting the cost and utilization of available resources and services; and

WHEREAS, Available information for informing the physicians and the public with regard to the cost of diagnostic tests, drugs and social services is woefully lacking and at times outdated; and

WHEREAS, Incentives to promote cost consciousness are an integral part of the responsibilities of the physician to his patient; therefore be it

RESOLVED, That the Illinois State Medical Society, through its delegation to the American Medical Association, request that the AMA encourage local hospital administrators to post prices of all services, supplies and drugs, with a constant updating of the changes; and be it further

RESOLVED, That these principles be presented for consideration by the AMA House of Delegates at its next meeting.

#### **Resolution 77A-19**

Introduced by: Joseph R. O'Donnell, M.D., for the DuPage County Medical Society

Subject: Committee of County Society with Medical Staff Officers

Referred to: Conference Committee D

WHEREAS, Coordinated health planning is now implemented by law; and

WHEREAS, Hospitals frequently plan services which may duplicate those available or being planned by other hospitals in the area; and

WHEREAS, Hospital medical staffs are the primary health care professionals who know what facilities are needed and available for patients; and

WHEREAS, The county medical society is the only areawide physician agency which can coordinate information about planning in hospitals in order to avoid unnecessary duplication; therefore be it

RESOLVED, That the Illinois State Medical Society and the American Medical Association encourage all county societies to form standing committees composed of medical society officers with presidents and immediate past presidents of all hospital staffs in their areas in order to guarantee a free-flow of information among physician hospital staffs.

#### **Resolution 77A-20**

Introduced by: Joseph R. O'Donnell, M.D., for the DuPage County Medical Society

Subject: Peer Review Fee Adjudication Appeals  
Referred to: Reference Committee D

WHEREAS, The basic authority and procedures for fee adjudication by peer review committees are at present set forth in Chapter XII of the Bylaws of the Illinois State Medical Society (and Chapter VIII with regard to District Committees); and

WHEREAS, Following the U.S. Supreme Court decision of *Goldfarb vs. Virginia State Bar Association*, adjudication of fees was in question because of anti-trust laws; and

WHEREAS, Recent legal opinion obtained by the Illinois State Medical Society led to a decision "to continue fee adjudication until such time as an investigation might be launched;" and

WHEREAS, The Executive Committee of the Illinois State Medical Society has placed in abeyance the matter of accepting fee adjudication appeals until a House of Delegates' decision in April; and

WHEREAS, There should at all times be due

process and an appeal mechanism in the conduct of fee adjudication by peer review committees in order to best represent the individual society members; therefore be it

RESOLVED, That the Illinois State Medical Society continue to accept fee adjudication from local medical society peer review committees on request; and be it further

RESOLVED, That decisions of the State Peer Review Committee shall at all times remain advisory only, and that final decisions are to be made only by the local county medical society peer review committee.

#### **Resolution 77A-21**

Introduced by: A. Beaumont Johnson, M.D., C. Larkin Flanagan, M.D., for the Board of Directors of the Illinois Foundation for Medical Care (IFMC)

Subject: Resolution 76N-64

Referred to: Reference Committee G

WHEREAS, the Illinois Foundation for Medical Care was created by act of the House of Delegates of the Illinois State Medical Society; and

WHEREAS, The Board of Directors of IFMC is composed in large part of individuals who are or have been members of the House of Delegates and Board of Trustees of ISMS and who are demonstrably loyal to ISMS; and

WHEREAS, The Directors of IFMC feel a responsibility, but not a documented obligation to be directly and appropriately responsible to the mandates of the ISMS House of Delegates; and

WHEREAS, The House of Delegates at its November, 1976, meeting in Peoria passed substitute Substitute Resolution 76N-64 pertaining to restructuring of IFMC bylaws; and

WHEREAS, The resolution, as passed, requested that this change should make the IFMC "completely accountable only to the House of Delegates through the Board of Trustees of ISMS, and to each component society of ISMS;" and

WHEREAS, Resolution 76N-64 resulted in a conflict of interest for participating members involved in their formative PSROs, the IFMC Board has a comparable conflict not resolved by limiting its membership to active trustees of ISMS; and

WHEREAS, Most of these Illinois physicians who have established local foundations will be disenfranchised of any direct voice in the governance of the parent foundation; and

WHEREAS, The act of changing the Constitution and Bylaws of an organization is agonizingly fundamental and one which should not be undertaken lightly nor carried through without clear understanding of the ultimate objectives to be achieved; therefore be it

RESOLVED, That this House of Delegates reconsider the accepted substitute Substitute Resolution 76N-64 for the purpose of clarification and more specific direction; and be it further

RESOLVED, That the House of Delegates fully divulge to the IFMC Board its desire with regard to the ultimate role of local foundations for medical care and their optimal relationship with the ISMS and the IFMC.

Note: This concludes the listing of resolutions received at *IMJ* production deadline. Additional resolutions should be forwarded to ISMS Headquarters, where they will be printed and distributed with the Delegates packet. In order to facilitate their preparation, delegates are urged to submit resolutions prior to March 20, 1977. Any resolutions submitted or received after March 27 will be considered late resolutions and be referred to the late resolutions committee.

# ANNUAL MEETING '77

The 137th Annual Meeting  
of the  
Illinois State Medical Society  
will be held at the  
Holiday Inn Mart Plaza  
Chicago, Illinois  
April 24-27, 1977

- ISMS House of Delegates
  - Specialty Society Scientific Programs
    - Gala President's Party
    - Public Affairs Breakfast
    - IMPAC Workshop

Further information about convention may be obtained by contacting the Illinois State Medical Society, 55 E. Monroe, Suite 3510, Chicago, Illinois 60603. Phone: (312) 782-1654

PLEASE RESERVE

FOR \_\_\_\_\_

CORPORATION \_\_\_\_\_

STREET \_\_\_\_\_

CITY/STATE \_\_\_\_\_ ZIP \_\_\_\_\_

NAME OF GROUP Illinois State Medical Society & ISMS Auxiliary OFFICIAL DATES APR. 23-27, 1977



Holiday Inn®  
MART PLAZA

Arrival Date _____		ACCOMMODATIONS	Circle Rate	Range Preferred
_____ am		<input type="checkbox"/> Single Room	\$38.00	\$40.00
Arrival Time _____ pm	(See Note Below)	<input type="checkbox"/> Double Room		
Departure Date _____		with Two Double Beds	\$46.00	\$48.00

Free parking for registered guests.

NOTE: All reservations will be held until 6 p.m. ☐ I am arriving after 6 p.m., please hold on Guaranteed Payment Basis. If rate is not available nearest available rate will be assigned.

All room prices are subject to city and state taxes.

B.A.C. # 370-328-1853



# IMPAC/AMPAC WORKSHOP

Monday, April 25, 1977

10:00 A.M.

Holiday Inn Mart Plaza

## "PRACTICAL POLITICS — THE HOW AND THE WHY"

### featuring

Rex Kenyon, M.D.

Chairman, American Medical Political Action Committee Board  
*The Road Ahead for Medical Politics*  
1977-1978

Douglas I. Bailey

President, Bailey, Deardourff, and Associates  
*The Media Conscious Physician*

Hon. Edward R. Madigan (R.-Ill. 21st)

Member of Congress

*Candidate Support—The Candidate's View*

George T. Wilkins, M.D.

ISMS President-elect and member of the AMPAC Board  
*You Can Help Your Candidate*

Donald A. Udstuen

Director, Governmental Affairs Division

Illinois State Medical Society

*That's The Way It Is—Springfield—1977*

Space limitations require advance registration. Questions: Telephone (312) 782-1963

☐ Yes, I'll be at the 1977 IMPAC/AMPAC WORKSHOP.

Name \_\_\_\_\_ Address \_\_\_\_\_

Phone \_\_\_\_\_

☐ I shall be staying for lunch.

Please return to: IMPAC  
Suite 3510  
55 East Monroe Street  
Chicago, Illinois 60603

Reservations confirmed on a first come/first served basis.



***Physicians and Auxiliaries  
of the Illinois State Medical Society  
are cordially invited  
to a complimentary  
Public Affairs Breakfast***

**7:30 a.m. Tuesday, April 26, 1977**

**Sauganash Ballroom**

**Holiday Inn Mart Plaza Hotel**

Space limitations require advance registration.

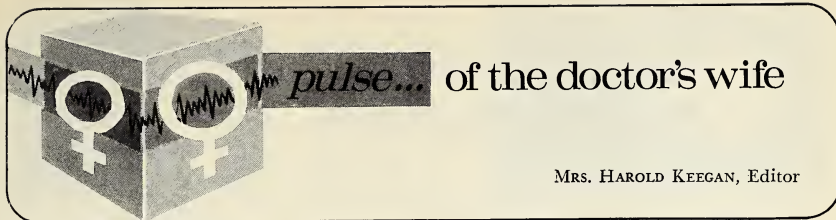
-----  
☐ **Yes, I will attend the Public Affairs Breakfast.**

**Name** \_\_\_\_\_ **Address** \_\_\_\_\_

**Phone** \_\_\_\_\_

Please return to: Public Affairs Committee  
Illinois State Medical Society  
Suite 3510  
55 East Monroe Street  
Chicago, Illinois 60603

Reservations confirmed on a first come/first served basis.



MRS. HAROLD KEEGAN, Editor

# Winter Board Meeting

The ISMS Auxiliary Winter Board Meeting was held January 25, 1977, at the Holiday Inn Mart Plaza, Chicago. State chairmen and district councilors presented their reports. Mrs. Eugene Vickery, chairman of the Nominating Committee, presented the following proposed slate of officers for 1977-1978.

## Proposed 1977 Slate

President	Mrs. Edward Szewczyk
President-Elect	Mrs. Earl Klaren
1st Vice-President	Mrs. William Hodges
2nd Vice-President	Mrs. Alton Morris
3rd Vice-President	Mrs. Harlan Failor
Recording Secretary	Mrs. Stanley Burris
Treasurer	Mrs. Robert Webb
Directors	Mrs. John Ovitz Jr.
	Mrs. Donovan Stiegel
	Mrs. Frank Holman

## Other Highlights

Mrs. Earl Klaren, 1st vice-president, stated that 56 letters were sent to the presidents of counties without organized auxiliaries requesting assistance in acquiring the home addresses of members and potential members.

Mrs. William Hodges, 3rd vice-president, stated that 15 projects have been requested from Illinois for the project bank.

Mrs. Robert Webb, 3rd vice-president, attended the Illinois School Health Conference and gained some very useful information.

Mrs. Alton Morris, legislation chairman, presented suggested clues for effecting contact with legislators.

The meeting adjourned shortly after James W. West, M.D., gave a short summary of the speech he will present at the April Annual Meeting, concerning the impaired physician.



Stephenson County auxiliaries have reported a most enjoyable meeting at their recent International Pot Luck Supper. The meeting was held at the home of Mrs. Thomas Koch, Stephenson County Auxiliary president. Pictured in the foreground (l-r) are Mrs. Lester Monn, Mrs. F. J. Lownik, Mrs. John Ovitz, Jr., ISMS Auxiliary president, and Mrs. Selig Hodes, ISMS AMA-ERF chairman.

## Film Available

A recent joint meeting of the St. Clair County Medical Society and the St. Clair County Medical Auxiliary featured "A Member of the Club," a film tracing a day in the life of a busy doctor—and that of his family. The film strip, which is highly recommended for auxiliary presentation, can be obtained by contacting: Spence Meighan, M.D., 1015 N.W. & 22nd Avenue, Portland, Oregon 97210, (503) 229-7137. The rental cost is \$100.00.

## Annual Meeting

The Auxiliary Agenda for the 1977 Annual Meeting in April is outlined in the ISMS Convention Handbook, page 204.



## membership forum

*Membership Forum is intended to serve as a communicative tool for ISMS Membership.*

*The Editors encourage comment and criticism on issues of the day.*

*Correspondence should be addressed to: IMJ, 55 E. Monroe, Suite 3510, Chicago 60603.*

# Nationalized Health Care: *An Analysis of the British Experience*

By JAMES W. SUTHERLAND, M.D./QUINCY

It is ominous that our legislators, almost without exception, are determined to follow the course of the British National Health Service without learning anything from its failings.

With the end of World War II, the Labor, or Socialist party, came to power and its NHS (National Health Service) Act of 1946 stated that "the medical service must be planned as a whole, must be preventive as well as curative and must be complete and open to all so that poverty shall be no bar to health".

From the outset, the main aspects of the British National Health Service were—

- It was completely comprehensive.
- It was available to everybody.
- It was completely free.

Like many new ideas, the theory of this was attractive, but performance was inept. The architects believed that if health care were made available to all, fitness would so improve that costs would become less and less. Not taken into consideration was the fact that patients would live longer and that costs would be added to the service at the geriatric end of the scale. It should have been obvious to these economists that Britain, or any other country, did not have the men or the money to carry out these three components of a national health service. Nobody carried out an actuarial study of the possible

costs. From its onset, the NHS was badly under-financed.

The resistance of family doctors was overcome by the promise that 2,500 health centers would be provided to cover the entire country. In 1974, some 26 years after the inception of the National Health Service itself in 1948, only 300 had been built and it was projected it would be 1980 before a total of 2,000 had been reached.

Before the enactment of the NHS, each doctor owned his practice and sold it when he wanted. After 1948, practices were nationalized and taken over by the government. General practitioners were no longer free to sell their practice nor could they move where they wanted. This could only be done by applying to the appropriate authority and by competing with the other GPs for a practice in a different part of the country.

While they waited for the promised health centers, they continued to practice in their own offices. The method of payment itself was reprehensible. In the beginning, they were allowed to take 3,500 patients on their list and were paid \$3 or less per head, per year, whether they saw the patients or not. So no matter how many house or office calls were made, the capitation fee remained at this figure. The harder the doctor worked the less he earned per hour. Where he had many old people

in his practice, he was clearly at times being paid nothing for many house calls, a tradition of medicine in Great Britain.

Spectacles, teeth, wigs and medicine were all free and the calls on them were so great that some small deductible was included to control it. In time, the list was reduced to 2,500 per doctor and the capitation fee at the moment is somewhere in the region of \$4 per head, per year, with a loading fee for older people and emergencies and obstetric cases.

The quality of service given by British doctors has always been a very high one and many struggled for years to maintain this standard. However, by 1966, the general practitioner was isolated from his patients in hospitals, overworked, underpaid and disillusioned.

Emigration of doctors occurred in large numbers. Hasty examination left the patient dissatisfied and one out of ten patients seen in the office were referred to the hospital, many having to wait several weeks to see a suitable consultant. Finally to quiet the revolt, the government gave them a substantial increase in capitation fee, bringing them up as closely as possible to the consultant in the hospital in terms of salary.

When the NHS Act became operative, the hospitals were nationalized



and only one to two per cent of the beds were placed aside for private practice. The consultants were paid on a basis of half-days. They were allowed to work full time on a basis of seven, eight or nine half-days per week, the remainder of the time being allotted to private practice.

Although it had been promised that private practice would continue, there was bias against it from the outset and a theory that it was improper to have two systems operating within one framework. Waiting lists grew longer and many business executives elected to join private insurance schemes which let them choose their own specialists and to get a private bed in a hospital, thereby enabling them to receive treatment more rapidly. "Jumping the line" became common practice and it was naturally resented.

The latest Labor government has had increasing trouble with the consultants who finally began to "work to contract". Instead of doing their customary 60 or more hours per week, they delivered the hours their contract demanded, 38½ hours per week full time. The juniors were paid overtime to take the place of their seniors and the situation deteriorated in the early months of 1975 until the consultants were given an increase in salary of the order of 30 to 35 per cent, at which point they stopped working to contract.

Then it was announced that the government meant to close all private beds in state hospitals and that private practice in the future would have to take place outside the system. For practical purposes, this was the death knell of private practice in Great Britain.

Other complications have been introduced by the fact that many of the non-medical staff in the hospital are unionized. They in turn resent the carrying out of private practice in hospitals and some have refused to have anything to do with any aspect of private practice in any state hospital.

All of this serves to illustrate the inevitable consequences of the mistakes that were made in the beginning. If it had been the intent of Labor and Conservative government in Great Britain to abolish private practice within the NHS, this should have been indicated from the outset. The hypocrisy has now come home to roost.

In the last five years, it has been estimated that the amount of money

earned by the British doctors relative to the cost of living has gone down by 38.5 per cent and one of them has said, "How then do we rate our training if an engine driver, a miner, a docker, or a salvage worker can receive wages as high as, if not higher than, those of many doctors".

The one aspect of the British National Health System which excites most envy amongst doctors in the United States is the almost total absence of malpractice suits since the patient is now suing not a doctor, but a branch of government. The British system of Medical and Dental Defense Unions made malpractice premiums very low indeed since in suing the doctor, they are in effect suing all doctors. Contingency fees are unknown and cases are carefully selected by a panel set up for this purpose. When they come to court, the plaintiff's case is pleaded by a barrister, i.e., a trial lawyer who is paid a very high fee but who cannot sue for it and who cannot be sued in turn for his performance. This system operates also in Canada where malpractice fees are low.

The British National Health Service, like any other, be it Dutch, Swedish or German, is rationed. From the outset, it has never had enough manpower or money to fulfill all the claims on it. There are not enough dollars to provide comprehensive, free, totally available medical care even here.

Something you get for nothing costs somebody something and by virtue of the fact that it is free is not appreciated by many to whom it is made available. There must be some method of limiting and monitoring abuses.

The citizens of the United States would do well to look before leaping into any program of total national health insurance. They should consider carefully the need and the cost. That there are needs is not open to doubt.

But all of these things can be taken care of by a process of evolution rather than one of revolution. There is much that is excellent in our present medical care. Our doctors are 100 per cent in favor of health care for everybody but not necessarily by federally administered programs.

There is no reason why we cannot proceed with a private catastrophic insurance against illness program which would remove the threat of bankruptcy from families who fall on bad times.

We are in great danger of becoming so impersonal that we become a mass of statistics, norms and computer data. Illinois Congressman Philip Crane, who is on the health subcommittee of the House Ways and Means Committee, has said, "when we are talking about senior citizens who can often ill afford the cost of medical care, we have the specter of a law like PSRO (Professional Standards Review Organization) PL 92-603 cutting people off from help because some statistical norm suggests that they do not need it. Let us rather begin with the able-bodied and have a "Welfare Standard Review Organization" or even an "Unemployment Compensation Standard Review Organization" and listen to the outcry from the liberals."

It is time to have a moratorium on health care legislation. There are so many laws and changing regulations in existence that the communication system is choked.

In response to federal intervention, the doctors of the United States from 1952 onwards have developed the concept of Foundations for Medical Care. These comprise the socio-economic arm of the county medical societies. Their primary objective is to provide for the preservation of the quality of medical care in these United States and to carry out utilization review and comprehensive health care and planning more cheaply and more efficiently than can be done by bureaucrats. Their origins were undoubtedly defensive in the sense that they were a response to the advent of PSRO (Professional Standards Review Organization) but they are now at the constructive phase. Their method of managing the problems are more economical than is achieved in Medicare and Medicaid, the figures for which remain a complete mystery.

The medical profession is steadily learning to discipline its members and to investigate objectively all examples of abuse of public funds and instances of unethical behavior. No other profession has undertaken the self-scrutiny that is taking place among physicians.

The doctors of the United States oppose nationalization and state control, not for their own interests but because excessive control limits our liberties and impoverishes the quality of our services leading to second-rate medical care. It is our responsibility to



all patients to see that the health dollar is well spent and the medically deprived are helped.

The above article is reprinted by permission from the Quincy HERALD-WHIG, Nov. 8, 1976, p. 7A. It was first published in a lengthier version, "Look Before You Leap" in the Worcester Medical News, Vol. 41, No. 5, May-June, 1976.

## Scoliosis: A Second Opinion

Dear Sir:

Drs. Newman and DeWald illustrate an important point in their article on Scoliosis (*Illinois Medical Journal*, 151:31 Jan. 1977). While their figure (1-a), does not clearly show the deformity of the spine, it *does better*. It shows the concavity of the thorax on the left side, as contrasted with the usual convexity on the right. Investigation of the thoracic contents in this case would show that the left lung is poorly developed. So the question arises, does the scoliosis cause asymmetrical deformity of the chest and its contents? . . . or does asymmetrical development of the endothoracic viscera cause the thoracic walls (of which the spine and ribs are part) to buckle and twist?

According to Piggott (*British Medical Journal*, 1:34-36, 1977), in the majority of cases, the cause of the scoliosis is unknown.

The etiology of this unexplained majority is clarified by the "Law of the Thorax" . . . "The thorax must not alone contain its viscera, it must fit them, while an intrathoracic viscus should fit its host and fellows".<sup>1</sup> Failure of the organs in one hemithorax, to grow and develop normally, leaves that half of the thoracic cavity with an inadequate mass of contents and therefore, unexpanded and unsupported. If that half of the thoracic cavity had grown normally and symmetrically, then there would be a vacuum inside, which of course is impossible.

Such a case requires that the hemithorax be smaller than normal, and/or be filled with viscera from elsewhere.

To a limited extent, other viscera do shift into the unfilled hemithorax.<sup>2</sup>

However, the main accommodation is for the hemithorax with inadequate contents to remain, or become, small because the thorax must fit its contents and vice versa. An asymmetrical deformity of the thoracic contents requires that the spine and ribs bend and twist so that the capacity of the thorax conforms to the size (and shape) of its contents.

The problem then is *not* really orthopedic, and an attempt to "correct" the secondary and necessary deformity, or rather conformity of the bones, (without reference to the Law of the Thorax) can prove fatal. If the surgeon is successful in "correcting" the bony deformities the patient ends up with one oversized lung (on which survival largely depends) being squeezed into a hemithorax wherein it cannot fit nor function properly. Meanwhile, the other hemithorax would have become a sort of vacuum, i.e., a space with less than commensurate contents.

Minor degrees of the thoracic deformity cause no real hardship, so "correction" is pointless. Attempts to "correct" major spinal deformities, which are really thoracic conformities, by destroying the unsightly but functional adaptation can quickly lead to death. Some do not even wake up after surgery and are erroneously confused with anesthetic complications.

One main reason for the existence of bones in the thoracic wall is to facilitate pulmonary function. So to "treat" the bones without reference to the lungs is unsound.

The lumbar spine forms part of the posterior abdominal wall. Since the belly is a single cavity and much of its other walls soft and yielding, the need for bending and twisting of the lumbar spine is rarely seen.

Discrepancy between the capacity of the abdomen and the mass of its contents does occur, but that is another story.<sup>2,3</sup>

Yours sincerely,  
M. G. Baggot, M.D.

### References

1. Baggot, M. G.: "Massive Collapse of the Lungs, Atelectasis and Intravascular Pulmonic Hypervolemia". *Am. J. Surg.* 85:184 (Feb.) 1953.
2. Baggot, M. G.: "Abdominal Disproportion in Pregnant, Surgical and Other Patients". *Current Researches*

in *Anesthesia and Analgesia*, 31:197 (May-June) 1952.

3. Baggot, M. G.: "Abdominal Blow-Out". *Current Researches in Anesthesia and Analgesia*, 30:295 (Sept.-Oct.) 1951.

## An Open Letter To Illinois House Staff

On behalf of the Advisory Committee of Physicians-In-Training, I would like to urge all Illinois house staff to provide a forceful and knowledgeable input at the ISMS Annual meeting in April.

The ISMS has been a leader nationally in involving house staff at all levels of the state society. We have voting representation on all ISMS councils, and a seated delegate in the ISMS House of Delegates. In the past we have functioned on a non-representative basis and are now reorganizing based on the nationwide model established by the AMA Resident Physicians Section (RPS) to incorporate proportionate representation in our state RPS. Our currently approved ISMS RPS Bylaws give each house staff organization representation on our governing council and there are also seats for those house staff in hospitals without house staff organizations. It is important for all graduate medical education programs to be represented. Your house staff organization and directors of medical education will be getting additional information for posting.

An eye-opening experience at the AMA Clinical Convention early in December made it evident that *all* physicians must be made aware of the rapidly changing regulations and laws which dictate how we will practice medicine for the rest of our careers. Our congressmen want input from medicine, and the AMA is just one of the interested groups that sit at the negotiating tables in our legislative capitals. Without active participation and input to this process, our profession will be subject to the mandate of those without the expertise we have to offer.

Some of the legal provisions of various bills which were DELETED after extensive pressure from the AMA and the ISMS are:

- 1) "Forced loans" for medical students requiring payback of federal capitation funds. (Deleted from PL 94-484).

2) Forced participation, by up to 50% of medical students, in National Health Service Corps scholarships, mandating federal servitude on a year-to-year basis. This would essentially have been a prerequisite for admission to medical school. Federal capitation funding would be removed for failure to comply. (Deleted from PL 94-484).

3) Home rule laws allowing each city and municipality to license physicians and test same. (Deleted from the revised Illinois State Constitution).

4) A program of strict federal control of residency programs and positions. (Deleted from PL 94-484).

Problems still facing house staff are numerous, including the recent National Labor Relations Board decision in the Cedars-Sinai case declaring that house staff are students, not employees. The National Board of Medical Examiners and the American Association of Medical Colleges are working together to rapidly change testing regulations and entrance requirements for graduate medical education to allow for greater control over house staff. Strong recommendations for limited licensure for residents is just one example.

If these statements upset you, as well they should, contact your ISMS Delegates! The RPS can meaningfully contribute to formulation of health policies and legislative decisions in our state. The RPS also serves to educate and train the future leaders of organized medicine in this country. Only by involvement can we hope to help shape the destiny of medical practice in our country. If you don't like the system, involvement is the first step in change.

Paul M. Stromborg, M.D.

President, Hines VA Medical

House Staff

Delegate, ISMS House of Delegates

## Nov. President's Page A Response

Dear Dr. Skom:

As a practicing M.D., a member of the Illinois State Medical Society, as well as a member of the Medical Examining Committee for the Department of Registration and Education of the State of Illinois, I find your comments on the *IMJ* President's Page about the Medical Examining Committee's decision as related to the C.M.E. law far from factual and very biased.

The C.M.E. law, as you know, affects not only M.D.'s but also osteopathic and chiropractic physicians. The Committee, in order to implement a law which would be the fairest to all concerned, held open hearings and invited a number of academicians and practitioners to state their comments on the meaning of the law. After extensive deliberation, it was felt that a basic review course or its equivalent for each relicensing period should be obtained and that 50 hours of continued education would be sufficient for the majority of doctors to keep abreast with the advances in medical knowledge. It was only on November 17, 1976, that a final draft was approved by a majority of the members. It was quite a surprise that you could make the following statement, "promulgated rules which make a mockery of its intent", before the final draft of the Committee was submitted.

It is a fact that a number of physicians, because of their position or type of practice, could easily accumulate 200 or 300 hours of C.M.E. study. However, I do not believe that the law was intended for the above category, but for the larger group who spend their days and nights in caring for the public instead of politicking. The members of the Examining Committee have devoted their valuable time in all sincerity to safeguard a balance of interest between the practicing physician and the health care of the receiving public.

If a single member's opinion was the basis for your comments condemning the whole Committee, I find it regrettable. My personal policy, as you probably know, has always been to bring better communication and co-operation between the Medical Examining Board and the various medical, osteopathic and chiropractic associations.

I hope this puts the matter of the Medical Examining Board and its members in proper perspective.

Sincerely yours,

Basil G. Chronis, M.D.

Member of the Board of

Medical Examiners

State of Illinois

*Dr. Skom replies:*

I am delighted to observe that Dr. Chronis has set the record straight and, even more important, that the

Medical Examining Committee took the action it did. This action was decidedly contrary to press accounts of statements emanating from the Medical Examining Committee, which formed the basis for my President's Page. I hope that my editorial and testimony helped to bring forth that action. Perhaps the article would have been more precise had the direct quotation of the Medical Examining Committee Chairman been cited.

## Medical School Quotas: Further Debate

The Editors, *IMJ*

Dear Friends:

National and State medical journals (Example: *IMJ*, 151:65, Jan. 1977) have had articles and letters criticising quotas for Black and "minority" medical students. These letters have characterized the quota system as a disservice to the community or to "minority" groups. These articles and letters could be called sophistry, if we used a kindly term, but more accurately it is sheer hypocrisy.

Numerus clausus to keep good students out is a crime, but numerus clausus to correct numerus nullus is a virtue. Almost a half-century ago, I was the secretary to the admissions committee of a medical school. In those days we had quotas on students who gave themselves the religious label (Jews) or a national origin label (Italians). The moral excuse was that if we had equality of opportunity, there wouldn't be any place left for anyone else.

Now I am on the faculty of a medical school, and find that the few Blacks and other "minority types" that are admitted are all outstanding students. The only people that I have heard complaining are those who wouldn't be admitted even if we returned to numerus nullus.

With all best wishes, I remain

Respectfully yours,

Roland I. Pritikin, M.D.

## And a Second Response

To the Editor:

Dear Sir:

I would like to reply to the open

letter in *IL Medical Journal* by S. Field:

I am glad that Mr. Field admits in his letter in *IL Medical Journal* 151: 65 (Jan. 77) that there have been inequities in the past in the admission policies towards minority applicants to medical school. He recognizes that a problem exists.

Mr. Field also states that the medical schools' responsibility is to train physicians. Without entering into argument over other tasks such as research, patient care, etc., I believe that he should go further in his definition. They should train *quality* physicians who are able to care for the needs of their patients. These patients are the rest of society, who are providing the public money with which he is so concerned.

In order to fulfill this role, medical schools must produce physicians who will provide care for all segments of society, not just a select few. To do otherwise is to renege on the responsibility delegated to the medical school.

The policy of admission to medical school that Mr. Field endorses leads to certain consequences. It must be recognized that maintenance of the *status quo* leads only to more inequities

in the delivery of health care. In 1975-76, only 6.2% of medical students in the U.S. were Black, and only 20.5% were female.<sup>1</sup> These figures are from a year in which "Affirmative Action Programs" were in force. Abolishment of these programs as Mr. Field proposes would cause a regression to such figures as those in the past, when even fewer minority students attended medical schools.

And just what does "talent" mean as a criteria for medical school admission? The talent to correctly fill little spaces on a computer-scored sheet? The talent to get "A's" in college? The talent to be born in a wealthy family? Or talent to be sensitive and compassionate? Does this talent include the desire to help a suffering fellow human, regardless of who he is?

I can only assume that Mr. Field wants grades and MCAT scores to be used as the criteria for admission. Does he recognize that the MCAT was so biased in the past that it has been completely changed? Administrators and officials of medical schools are now recognizing that good grades don't always make for a good physician. A lit-

erature review by J. R. Wingard and J. W. Williamson entitled "Grade as Predictors of Physician Career Performance," concluded, "That which was reviewed is consistent in indicating little or no correlation between the two factors."<sup>2</sup>

With Mr. Field's criteria, white wealthy males with parents and friends in the profession will be entering medical school. These future physicians will provide care for the segments of society from which they came as studies have shown,<sup>3</sup> while other segments suffer from inadequate health care.

Jason Chao

Student Member,  
IL State Medical Society

#### References

1. 76th Annual Report, Medical Education in the United States, 1975-1976. *JAMA* 236:26.
2. Wingard, J. R., and Williamson, J. W., "Grades as Predictors of Physician Career Performance: An Evaluative Literature Review." *Journal of Medical Education* 48:311.
3. Cooper, J. K., et al., "Rural or Urban Practice: Factors Influencing the Location of Primary Care Physicians." *Inquiry* 12(1):18-25.

## ★ *Specialized Service*

IN  
PROFESSIONAL LIABILITY INSURANCE

*is a high mark of distinction*

**THE  
MEDICAL PROTECTIVE COMPANY**  
**FORT WAYNE, INDIANA**

*Professional Protection Exclusively since 1899*

#### CHICAGO AREA OFFICE:

T. J. Pandak, J. C. Kunches, L. R. Gannon, and W. G. Prangle, Representatives  
814 Commerce Drive, Suite 101B, Oak Brook, Illinois 60521 (312) 325-7314

SPRINGFIELD OFFICE: W. J. Nattermann, Representative  
426½ South Fifth Street, Springfield 62701 (217) 544-2251



# 21st Annual Meeting AAMA Illinois Society

Holiday Inn, Bradley, Il

April 28-May 1, 1977

## Grow With Knowledge and Friendship

### THURSDAY, APRIL 28, 1977

6:00 p.m.-9:00 p.m. Registration  
8:00 p.m. Opening of Exhibits  
8:30 p.m. Hospitality Parties

### FRIDAY, APRIL 29, 1977

7:30 a.m.-5:00 p.m. Registration  
8:00 a.m.-9:45 a.m. Council Meeting  
10:00 a.m.-11:00 a.m. House of Delegates Luncheon  
11:00 a.m.-12:15 p.m. Reference Committees  
12:30 p.m.-3:00 p.m. House of Delegates (Reconvenes)  
3:15 p.m.-5:30 p.m. Pictures  
7:00 p.m. Cocktails  
7:30 p.m.-8:00 p.m. Presidents' Dinner

### SATURDAY, APRIL 30, 1977

7:00 a.m.-8:15 a.m. President President-Elect Breakfast  
7:45 a.m.-8:15 a.m. Continental Breakfast  
8:00 a.m. Registration  
8:30 a.m. EDUCATIONAL SESSION  
8:30 a.m.-10:00 a.m. Walter S. Feldman, M.D., J.D., F.C.L.M.  
"Dealing With Difficult Patients"

10:00 a.m.-10:15 a.m.

10:15 a.m.-11:15 a.m.

Coffee Break

Joseph A. Koprowski, Attorney at Law

"Medical Assistant—A Profession With Inherent Risk"

Awards Luncheon

EDUCATIONAL SESSION

RESUMES

Ben C. Happach, C.C.C.E., C.M.P.A.

"Management of Patient Accounts"

Robert J. Kramer, M.D., F.A.C.S.

"You and the Federal Government"

### NOTE:

Continuing Education Unit Credit pending for all four speakers  
Pictures

5:30 p.m.

6:30 p.m.-7:30 p.m.

7:30 p.m.

10:00 p.m.

Cash Bar

Installation Banquet

President's Reception

### SUNDAY, MAY 1, 1977

9:00 a.m.

Farewell Breakfast

Jeanne D. Green, CMA-A, AAMA

President-Elect

Council Meeting

11:00 a.m.

### Registration Form:

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Chapter: \_\_\_\_\_ Member \_\_\_\_\_ Non-member \_\_\_\_\_

Employer: \_\_\_\_\_

Address: \_\_\_\_\_

Delegate: \_\_\_\_\_ Alt. Delegate: \_\_\_\_\_ Councilor: \_\_\_\_\_

Alt. Councilor: \_\_\_\_\_ Officer: \_\_\_\_\_ Advisor: \_\_\_\_\_

Is this your first convention?

Yes: \_\_\_\_\_ No: \_\_\_\_\_

General Registration Fee (Member):

\$40.00

LATE FEES: \$50.00

General Registration Fee (Non-member):

\$50.00

General Registration Fee (Student):

\$30.00

LATE FEES: \$40.00

Saturday Educational Program & Luncheon:

\$15.00

Inaugural Dinner:

\$12.00

Friday Presidents Dinner:

\$10.00

Sunday Morning Breakfast:

\$ 5.00

Total Amount Enclosed:

\$

### REGISTRATION DEADLINE:

APRIL 15, 1977

Please mail this form with registration fee payable to:

Illinois Society Convention Fund

Mrs. Carol Zens, 552 S. Walnut, Chebanse, Illinois 60922

Hotel reservations must be received by Holiday Inn at least 30 days prior to the convention.



## Physician Recruitment Program

*In an effort to reduce the number of towns in Illinois needing physicians, the Physician Recruitment Program and the Doctor's Job Fair, are publishing synopses in the Journal.*

*Physicians who are seeking a place to practice or who know of any out-of-state physicians seeking an Illinois residence are asked to notify the Program.*

*Any areas wishing to be listed should contact: Mrs. E. Duffy, Physician Recruitment Program, ISMS, 55 E. Monroe, Suite 3510, Chicago, 60603.*

**CAIRO:** Community Hospital with 20,000 population, staff of 1 Dentist, 1 Pediatrician, 1 OB/GYN, 2 General Surgeons, 1 Internist seeking ambitious General Practitioner for rural community. Recreation, (boating, fishing on lakes, rivers; golf, tennis), education, (public, private and parochial). Financial assistance in moving, office space, staff. Excellent potential. Contact: Harvey Pettry, PADCO Community Hospital, Cairo, 62914. 618-734-2400. (5)

**CARBONDALE:** Family Physician: Innovative neighborhood center in Southern Illinois seeks family practice physician to provide patient care and supervise other professionals and paraprofessionals in a clinic setting. Salary negotiable. Position available March, 1977. Contact: Robert Stalls, Director of Human Resources, City of Carbondale, 609 E. College, Carbondale, (618-549-5302). (6)

**CARTHAGE:** County Seat for Hancock County (Population 24,000). Need for Internist, Family Practice, and ER Physicians willing to conduct family practice. Memorial Hospital will guarantee first year income and provide office space. Four physicians and two surgeons at present. Contact: Harold A. Dietz, Administrator, Memorial Hospital, Carthage, 62321. 217-357-3131. (5)

**CHADWICK:** Rural area in northwestern corner of Illinois. Population 600. Strong farming community. Need general practitioner to set up solo practice. Office facilities available. Contact: Harold Frank, Box 38, Chadwick, 61014. (815) 684-5154 or 684-5147. (5)

**CHESTER:** The Menard Correctional Center is presently searching for an Illinois Licensed physician, GP or IM. Duties will include daily sick call, admission physicals and histories, daily rounds in institution medical unit and segregation unit. Salary dependent upon training and experience, and fringe benefits including malpractice insurance. Write: Cecil Patmon, Administrator, Medical Services, 160 North LaSalle, Room 425, Chicago 60601, or call collect 312-793-3216.(4)

**CHICAGO HEIGHTS:** 35 man multispecialty group needs Board certified or eligible family practitioner. Located in 100,000 sq. ft. building. Ancillary services available include X-ray, lab, cardiology stress testing, physical therapy, speech therapy, biofeedback, optical shop, pharmacy. Plans for further expansion with investment opportunities. Call Mr. H. Cloys, 333 Dixie Hwy., Chicago Heights, 60411. 312-756-7447. (5)

**FORT MADISON, IOWA:** Openings for 2 FP/GP, OB, PED, Int. in growing industrial city of 16,000 serving 70,000 on Miss. River. Solo, partnership, clinic avail-

able. Substantial salary, other incentives. U. of Ia. near, Excellent living area, 125 bed accredited hospital. Contact: Donald A. Buckert, Sacred Heart Hospital, Fort Madison, Ia. 52627. 319-372-6530. (5)

**HERRIN:** Trade area of 40,000. Sportsman's paradise of Southern Illinois. 20 minutes from S.I.U. and Medical School. Internal Medicine and Family Practice needed now. Partnerships and solo available. Modern office facilities. Financial assistance. Contact: Larry Fell, Herrin Hospital, Herrin, 62948. (618) 942-4710. (5)

**HOMER:** Family Practitioner—Eleventh ranking county in U.S. gross farm income; 20 min. to large town with two hospitals; drawing area 12,000; house and office building offered; town may help with equipment. Contact: Douglas Driscoll, RR2, Homer, 61849. (217) 896-2434. (5)

**ILLIOPOLIS:** Needed Family Physician for small community. Surrounding area about 6,000 population. Industrial practice possible. Twenty miles from five major hospitals, on Interstate. Financial assistance available. Will work with you on office facilities. Contact: John Burke, R.R. 1, Illiopolis, 62539. Daytime—(217) 753-4861; night—(217) 486-6009—collect. (5)

**JACKSONVILLE:** Two-college town of 26,000 needs Primary Care Physicians. Excellent opportunity for F.P.s and Internists to join young, 37-member staff, expanding hospital, and progressive medical climate where patient care is the bottom line. Med. school 35 min's with good teaching opportunities. Contact: Larry Bear, Passavant Hospital, Jacksonville, 62651. (217) 245-9541. (5)

**KANKAKEE:** Physician needed for area-wide trauma center in a 300 bed hospital. Emergency Medical training or training in primary care medicine is required. Salary commensurate with training and experience. Please contact Dr. R. Schuller at 500 West Court Street., Kankakee, Illinois 60901 or phone 815-937-2410. (6)

**LA SALLE-PERU:** Area population 35,000. Opportunities in hospital for family practice, internal medicine, pediatrics, OB-GYN. Twenty-five physicians at present with several over age 55. Two hours from Chicago. Office facilities, Financial assistance available. Numerous recreational facilities, good schools and housing. Contact: W. Schweickert, 925 West Street, Peru, 61354. (815) 223-3300. (5)

**LITCHFIELD:** Emergency Physician Opening—Join two full-time physicians staffing a Trauma Center in new hospital. Excellent salary, flexible scheduling to allow ample time for hobbies and leisure. Comfortable community of 8,000 with beautiful 1700 acre lake

bordered by wooded homesites. Community interests include boating, fishing, hunting, farming, houses, golf, tennis, private flying and amateur theatre. One hour's drive to St. Louis or Springfield. Contact: Lee Johnson, M.D. or Jim Bohl at (217) 324-2191, St. Francis Hospital, Litchfield, 62056. (5)

**MENDOTA:** (City population 8000—service area 20,000). New medical clinic building next to hospital. Small town living with social and educational benefits of Chicago and other metropolitan areas close at hand. Financial assistance available. Busy practice available. Contact: E. E. Williams, Memorial Dr. & Rt. 51, Mendota, 61342. (815) 539-7461. (5)

**MORRIS:** Orthopedist and family practitioner urgently needed. Excellent opportunities for both in this rapidly growing rural community on Interstate 80 one hour from Chicago. Accredited 75-bed general hospital with new services and equipment planned. Service area 25,000-30,000. Contact: L. Wilhelm, M.D., P.O. Box 729, Morris, 60450. (815) 942-5474. (5)

**NEW ATHENS:** Population 2,200 (area population 17,000), 35 miles from St. Louis, Mo. Need one or two family physicians for new medical building. "Big city" attractions; best of shopping, recreation, and educational opportunities nearby. 1100 hospital beds within 20 minutes. Contact: Earl Becker, New Athens, 62264 or call collect (618) 475-2602. (5)

**ORLAND PARK:** Orland Park and far S.W. Chicago office, need general practice physicians, complete facilities both offices. New office bldg. completed Dec. 1, 1976. Contact: C. E. Cornelison, Adm., 10444 S. Kedzie, Chicago 60655, (312) 239-3000. (4)

**PEKIN:** Population 32,000. Hospital service area +50,000. Affiliated with Peoria School Medicine. 230-bed J.C.A.H. approved; well-equipped. Personal and capital financial assistance available. Ten miles to Peoria. Emergency services under contract. Opportunities for partnerships available. Contact: T. Larson or R. Tucker, M.D., Pekin Memorial Hospital, Pekin, 61554. (309) 347-1151. (5)

**PEORIA:** Faculty for expanding emergency medicine residency program of 832 bed general university affiliated hospital. Immediate position available and second available July, 1977. Inquiries limited to board certified specialists and/or graduates of ER programs. Positions combine academic and ER medicine. Send C.V. and references to: Ronald E. Pechan, Assistant Administrator, St. Francis Hospital-Medical Center, 530 N.E. Glen Oak Avenue, Peoria, 61637, (309) 672-2298. (6)

**PRINCETON:** New physicians offices under construction at Perry Memorial Hospital which serves Bureau County, population 40,000. Two hours southwest of Chicago. All recreational facilities available, good schools and comfortable living in country style. Contact John Revell, 606 South Main Street, Princeton, 61356. AC/815-875-4444. (6)

**ROCK ISLAND:** Excellent opportunity for family practitioners at new medical center physician's office building, rent free the first year. A substantial income guarantee and financial assistance are available. Contact: Thomas J. Lavery, Dir. Physician Recruitment, Rock Island Franciscan Hospital, 2701-17th Street, Rock Island, 61201. (309) 793-1000 (call collect). (5)

**RUSHVILLE:** Sixty miles west of Springfield. Progressive, growing community with 80 bed hospital serving population 12,000 to 15,000. Excellent schools, churches, shopping, recreation including a lake, golf course, pool, hunting and fishing. Office space with active physician, or private practice. Financial assistance. Contact: Charles Berry Jr., Administrator, Culbertson Hospital, Rushville, 62681. (217) 322-4321. (5)

**SILVIS:** Primary Care Physicians (Family Practice, Internal Medicine, Pediatrics) wanted to locate in new medical building adjacent to suburban hospital in Illinois Quad-Cities. Guarantee offered. For additional details write or call Noel Lee, M.D., 4430-34th Avenue, Moline, 61265. (309) 797-5811. (5)

**SPRINGFIELD:** Currently seeking family practitioners, internists, and an otolaryngologist to establish practice in new Community Medical Plaza. We offer many benefits and assistance to help physicians get started. If interested, call collect: (217) 529-7151 or write to: Diana Smalley, 5230 South 6th Street-Frontage Road, Springfield, Illinois 62703. (5)

**STERLING/ROCK FALLS:** Population 28,000. Immediate need for Cardiologist (non-invasive) and E.N.T. Has progressive 167 bed JCAH hospital serving 80,000 people with unlimited growth potential, all in a pleasant community with excellent recreational facilities. Contact: Dallas K. Larson, Administrator, Community General Hospital, Sterling, 61081. (815) 625-0400. (5)

**WHITEHALL:** Area population 12,000. Urgent need for family practice or general practice. Excellent educational, cultural and recreational environment. Licensed 30 bed hospital. Office, housing, and financial assistance available. Excellent opportunity for man or woman. George A. Stahl, 407 No. Main, White Hall, 62092. (217) 374-2444. (5)

## EKG

(Continued from page 166)

Answers: 1. A,B,C, 2. E

Although cardiovascular control is located in the brainstem and in the hypothalamus, stimulation of the cerebral cortex has produced marked changes in the ECG. These include sinus bradycardia or tachycardia, premature beats, sinus node block or arrest, and AV junctional rhythm. Excessive vagal tone is apparently to blame for some of these effects. (*Circulation* 26:683, 1962). Many reports have documented the striking ST-T wave changes that can occur with subarachnoid hemorrhage, as well as cerebral hemorrhage. This patient's anticoagulation went out of control despite bimonthly monitoring of the prothrombin time. His ECG on admission was normal. Postoperatively he never regained consciousness. The rhythm strip really shows severe sinus bradycardia with arrhythmia but some degree of sinoatrial block could not be ruled out. Despite evidence of brain death, the pulse was still full and bounding. Since there was evidence of brain death, no treatment is indicated.



## PHYSICIAN OPPORTUNITY

Major Chicago area hospital is seeking board certified Physician to assume responsibility for admissions department, employee health service, emergency unit, ambulatory care, intermediate care and a community health network, with excellent potential for program expansion.

Excellent salary and fringe benefits, including free malpractice coverage.

Qualifications: M.D. American Board of Preventive Medicine (or equivalent board), Illinois licensure or eligibility. Send curriculum vitae in all confidence to:

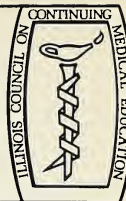
Box 879, c/o Illinois Medical Journal,  
55 E. Monroe, Suite 3510,  
Chicago, 60603.

An Equal Opportunity Employer M/F



# ISMS Guide to Continuing Medical Education

Compiled for Illinois physicians by the  
ILLINOIS COUNCIL ON CONTINUING MEDICAL EDUCATION  
55 E. Monroe St., Suite 3510 • Chicago, IL 60603 • (312) 236-6110



Items for this Calendar must be received 90 days prior to the event. Those received earlier may appear in up to three monthly issues.

**WARNING!** Items for this Calendar come from many sources, often far in advance of the publication date. Sometimes, cancellations or changes in date, place or time occur too late to be corrected before publication. You are urged to contact the sponsoring organization to confirm information given below.

## APRIL

### Continuing Medical Education

**MANDATORY CME—ITS IMPLICATIONS IN ILLINOIS FOR PHYSICIANS, HOSPITALS, & MEDICAL SCHOOLS**  
For: Anyone interested in CME. Workshop. April 15, 7:30-9:30pm & April 16, 9:00am-5:00pm. Oak Brook Hyatt House, Oak Brook. CME Credit: 9 hrs. AMA Cat. 1. Fee: \$50. Reg. Limit: 100. Sponsor, contact: Illinois Council on Continuing Medical Education, 55 E. Monroe St., Suite 3510, Chicago, IL 60603. Telephone: (312) 236-6110.

### Dermatology

#### SOME NEW THOUGHTS ON THE TREATMENT OF CONNECTIVE TISSUE DISEASES

For: Physicians. Lecture (Samuel M. Bluefarb). April 20, 11:00am. Northwestern University Medical School, Chicago. Speaker: Dr. Charles J. McDonald, Brown University. Fee: None. Sponsor, contact: Northwestern University Medical School, Dept. of Dermatology, 303 E. Chicago Ave., Chicago, IL 60611. Attn: Eleanor Sok. Telephone: (312) 649-8618.

### Emergency Medicine

#### ILLINOIS COMBINED SCIENTIFIC ASSEMBLY—"MOVING ON"

For: Emergency Care Physicians and Nurses. 2½ day Symposium. April 14-16 (1½ day for Paramedics). Hyatt Regency O'Hare, Chicago. CME Credit: 20 hours AAFP Elective, ACEP. Fee: ACEP member \$100, non-member \$110; EDNA member \$80, non-member \$90. Reg. Deadline: May register anytime; late registration fee after March 15. Sponsor, contact: American College of Emergency Physicians, 10316 S. Laverne, Oak Lawn, IL 60453. Attn: Alan B. Spaone, M.D. Co-sponsor: Emergency Department Nurses Association.

### Family Medicine

#### FAMILY PRACTICE REVIEW

For: Primary Family Practitioners. Lecture. April 25-One Week-8:30 am. Cook County Graduate School of Medicine, Chicago. Speaker: Sheldon S. Weidman, M.D. (Coordinator). CME Credit: 45 hrs. AMA Cat. 1. Fee: \$200. Reg. Limit: 125. Sponsor, contact: Cook County Graduate School of Medicine, 707 S. Wood St., Chicago, 60612. Attn: Robert J. Baker, M.D., Dean. Telephone: (312) 733-2800.

### Heart Surgery

#### HEART SURGERY—PAST, PRESENT AND FUTURE

For: M.D.'s (of special interest to cardiovascular surgery residents, etc.). Lecture. April 1, Martha Washington Hospital, Chicago. CME Credit: 1 hr. AMA Cat. 1; AAFP. Fee: None. Reg. Limit: 100. Reg. Deadline: March 31. Sponsor, contact: Martha Washington Hospital, 405 N. Western Ave., Chicago, 60618. Attn: Fernando Villa, M.D., Medical Director. Telephone: (312) 583-9000 ext. 331.

### Medical History

#### D. J. DAVIS LECTURE IN MEDICAL HISTORY: MEDICINE ON STAGE: VAUDEVILLE AND THE MEDICAL PROFESSION 1900-1920

For: All interested in Medical History. Lecture. April 6, 12:30 pm. Univ. of Ill. College of Medicine, Chicago. Speaker: Dr. Allen G. Dubus, Univ. of Chicago. Fee: None. Sponsor, contact: University of Illinois College of Medicine, Div. of Urology, U. of Ill. at the Med. Ctr., P.O. Box 6998, Chicago, 60680. Attn: Dr. J. H. Kiefer. Telephone: (312) 996-6771 (Miss Wilcox).

### Medical/Surgical

#### THIRTEENTH MEDICAL/SURGICAL SEMINAR FOR LAKE COUNTY

For: Physicians, Dentists, Nurses, Pharmacists. Seminar Symposium. April 27, 8:45am-1:00pm. St. Theresa Hospital, Waukegan. Speakers: Joseph A. Caprin, M.D., Donald G. Vidd, M.D., and Charles A. Crenshaw, M.D. CME Credit: 5 hrs. AMA Cat. 1; AAFP Elective. Fee: None. Reg. Deadline: April 25. Sponsor, contact: St. Theresa Hospital, 2615 W. Washington, Waukegan, IL 60085. Attn: R. M. Adelman, D.D.S., M.D. Telephone: (312) 688-5800.

### Medicine

#### STATE & NATIONAL BOARD REVIEW (BASICS)

For: Internists & Foreign Medical Graduates. Lecture. April 24-6 ½ days-1:00 pm. Cook County Graduate School of Medicine, Chicago. Speaker: Sheldon S. Weidman, M.D. (Coordinator). CME Credit: 58 hrs. AMA Cat. 1. Fee: \$225. Reg. Limit: 150. Sponsor, contact: Cook County Graduate School of Medicine, 707 S. Wood St., Chicago, 60612. Attn: Robert J. Baker, M.D., Dean. Telephone: (312) 733-2800.

### Musculoskeletal Trauma

#### CLINICAL HOSPITAL PROGRAM ON TRAUMA

For: All physicians. April 19, 8:00pm-10:00pm. Mercy Hospital & Medical Center, Chicago. CME Credit: 2 hours AMA Cat. 1; AAFP Elective. Fee: None. Sponsor, contact: Chicago Committee on Trauma, American College of Surgeons, 11255 W. 74th St., LaGrange, IL 60525. Attn: Mrs. Lillian Husa. Telephone: (312) 246-3788 or 482-8686.

### Pediatrics

#### NEONATAL RESPIRATORY CARE

For: Physicians, Res. Therap., Anesthesiologists, Nurses. 2-day workshop. April 5-6, 9:00am-5:00pm. Holiday Inn-City Center, Chicago. Speakers: Eduardo Bancalari, M.D., & Robert Kirby. CME Credit: 12 hrs. AMA Cat. 1. Fee: \$45. Reg. Deadline: March 22. Reg. Limit: 100. Sponsor, contact: Univ. of Ill. Dept. of Pediatrics, Univ. of Ill. @ the Medical Center, Office of Continuing Education Services, 1853 W. Polk St., Room 144, Chicago, IL 60612. Attn: SBA Korinek. Telephone: (312) 596-8025. Co-sponsor: Chicago Lung Association.

#### EVALUATION OF RECURRENT INFECTIONS

For: All interested physicians. Lecture series. April 6, 9:00 am. St. Joseph Hospital, Chicago. Speaker: A. Todd Davis, M.D. CME Credit: 1 hr. AMA Cat. 1. Fee: None. Sponsor, contact: St. Joseph Hospital, 2900 N. Lake Shore Drive, Chicago, 60657. Attn: Tina Dabrowski. Telephone: (312) 975-3454. Co-sponsor: Senator Everett McKinley Dirksen Memorial Fund.

#### SPECIALTY REVIEW COURSE IN PEDIATRIC SURGERY

For: Pediatricians (Prep. for Board). Lecture. April 11, 9:00 am, 5 days. Cook County Graduate School of Medicine, Chicago. Speaker: Ira Rosenthal, M.D. (Coordinator). CME Credit: 38 hrs. AMA Cat. 1. Fee: \$225. Reg. Limit: 85. Sponsor, contact: Cook County Graduate School of Medicine, 707 S. Wood St., Chicago, 60612. Attn: Robert J. Baker, M.D., Dean. Telephone: (312) 733-2800.

#### OTITIS MEDIA, URINARY TRACT INFECTIONS, OSTEOMYELITIS

For: All interested physicians. Lecture series. April 13, 9:00 am. St. Joseph Hospital, 2900 N. Lake Shore Drive, Chicago. Speaker: A. Todd Davis, M.D. CME Credit: 1 hr. AMA Cat. 1. Fee: None. Sponsor, contact: St. Joseph Hospital, 2900 N. Lake Shore Drive, Chicago, 60657. Attn: Tina Dabrowski. Telephone: (312) 975-3454. Co-sponsor: Senator Everett McKinley Dirksen Memorial Fund.

### "RECENT CHANGES IN THE STRUCTURE OF THE FAMILY"

For: Mental health care professionals. Lecture. April 20, 1:00 PM-4:00 PM. Riveredge Hospital, Forest Park. Speakers: Bruno Bettelheim, Ph.D., Director Emeritus; Sonia Shankman, Orthogenic School of Univ. of Chicago. CME Credit: 3 hrs. AMA Cat. 1. Fee: \$10. Reg. Limit: 200. Reg. Deadline: Reservations 771-7000 ext. 342. Sponsor, contact: Riveredge Hospital Foundation, 331 W. Roosevelt Road, Forest Park, IL 60130. Attn: John Pontarelli. Telephone: (312) 771-7000 ext. 305.

### Psychiatry

#### "THERE AIN'T NO PILLS, YOU'VE GOT TO DO IT YOURSELF"

For: Professionals and Students in the Health Field. Lecture. April 13, 7:30 to 9:30pm. Forest Hospital Professional Center, Des Plaines. Speaker: Robert Goulding, M.D., Director and Co-founder of the Western Institute for Group and Family Therapy. CME Credit: 2 hours AMA Cat. 1. Fee: \$15 prof.; \$5 students. Reg. Limit: 100. Reg. Deadline: Advance registration requested. Sponsor, contact: Forest Hospital Foundation, 555 Wilson Lane, Des Plaines, IL 60016. Attn: Leo Jacobs, M.D. Telephone: (312) 827-8811.

#### DSM III: RATIONALE, PROBLEMS AND PROSPECTS

For: Psychiatrists. Distinguished lecture series. April 20, 8:00pm. Passavant Hospital, Chicago. Speaker: Robert L. Spitzer, M.D., Director, Evaluation Section Biometric Research, N.Y. State Dept. of Mental Hygiene. CME Credit: 1½ hrs. AMA Cat. 1. Fee: None. Sponsor, contact: Institute of Psychiatry, Northwestern University Medical School, 320 East Huron, Chicago, IL 60611. Attn: Jeanne Smith. Telephone: (312) 649-8058.

### Surgery

#### SURGERY OF THE G.I. TRACT

For: Surgeons. Lecture. April 11, 8:00 am—One Week. Cook County Graduate School of Medicine, Chicago. Speaker: Robert J. Baker, M.D. (Coordinator). CME Credit: 40 hrs. AMA Cat. 1. Fee: \$200. Reg. Limit: 55. Sponsor, contact: Cook County Graduate School of Medicine, 707 S. Wood St., Chicago, 60612. Attn: Robert J. Baker, M.D., Dean. Telephone: (312) 733-2800.

### Urology

#### SPECIALTY REVIEW IN UROLOGY (PREP. FOR BOARD)

For: Urologists. Lecture. April 20, 8:30 am—4 days. Cook County Graduate School of Medicine, Chicago. Speaker: Irving M. Bush, M.D. (Coordinator). CME Credit: 32 hrs. AMA Cat. 1. Fee: \$175. Reg. Limit: 125. Sponsor, contact: Cook County Graduate School of Medicine, 707 S. Wood St., Chicago, 60612. Attn: Robert J. Baker, M.D., Dean. Telephone: (312) 733-2800.

### CANCER INFORMATION SERVICE FOR ILLINOIS

800-972-0586

Illinois physicians may call this toll-free number for quick, easy access to a panel of cancer specialists for specific patient consultation.

Sponsored by:

Illinois Cancer Council  
37 South Wabash Avenue  
Chicago, IL 60603



## ABSTRACTS REQUESTED FOR ILLINOIS HEALTH CARE RESEARCH SYMPOSIUM

Abstracts should follow the APHA format and can be on a variety of health care topics which include Illinois-based empirical data.

For information write or call:  
Program Committee, Illinois Health  
Care Research Symposium  
SIU School of Medicine,  
P.O. Box 3926  
Springfield, IL 62708  
(217) 782-5770

## MAY

### Anesthesia

**SPECIALTY REVIEW COURSE IN ANESTHESIOLOGY**  
For: Anesthesiologists. Lecture, May 21, 9:00 am—One week. Cook County Graduate School of Medicine, Chicago. Speaker: Alan P. Winokur, M.D. (Coordinator). CME Credit: 40 hrs. AMA Cat. 1. Fee: \$200. Reg. Limit: 300. Sponsor, contact: Cook County Graduate School of Medicine, 707 S. Wood St., Chicago, 60612. Attn: Robert J. Baker, M.D., Dean. Telephone: (312) 733-2800.

**REGIONAL ANESTHESIA & THERAPEUTIC NERVE BLOCKING**  
For: Anesthesiologists. Lecture, May 30, 9:00 am—One week. Cook County Graduate School of Medicine, Chicago. Speaker: Vincent J. Collins, M.D. (Coordinator). CME Credit: 40 hrs. AMA Cat. 1. Fee: \$300. Reg. Limit: 30. Sponsor, contact: Cook County Graduate School of Medicine, 707 S. Wood St., Chicago, 60612. Attn: Robert J. Baker, M.D., Dean. Telephone: (312) 733-2800.

### Dermatology

**SPECIALTY REVIEW COURSE IN DERMATOLOGY**  
For: Dermatologists. Lecture, May 2, 9:00 am—One week. Cook County Graduate School of Medicine, Chicago. Speaker: Marshall Blankenship, M.D. (Coordinator). CME Credit: 35 hrs. AMA Cat. 1. Fee: \$200. Reg. Limit: 75. Sponsor, contact: Cook County Graduate School of Medicine, 707 S. Wood St., Chicago, 60612. Attn: Robert J. Baker, M.D., Dean. Telephone: (312) 733-2800.

### Family Medicine, Pediatrics,

### Internal Medicine

**THE TREATMENT AND MANAGEMENT OF EPILEPSY IN CHILDREN AND ADOLESCENTS**  
For: Family Practice, General Practice, Pediatrics & Internal Medicine. One-day program, May 16, University of Illinois Medical Center Campus. Speaker: Dr. Philip Forman. Fee: \$35; \$15 (residents). Reg. Limit: 80. Reg. Deadline: May 2. Sponsor, contact: Dept. of Neurology, Abraham Lincoln Sch. of Med., U. of I. College of Medicine, Office of Cont. Educ. Services, 1853 W. Polk St., Room 144, Chicago, IL 60612. Attn: Sarah Brown. Telephone: (312) 996-8025.

### Medicine

**STATE & NATIONAL BOARD REVIEW (CLINICAL)**  
For: Internists. Primary for Family Practitioners. Lecture, May 2, 8:00 am—6 days. Cook County Graduate School of Medicine, Chicago. Speaker: Sheldon S. Waldstein, M.D. (Coordinator). CME Credit: 53 hrs. AMA Cat. 1. Fee: \$225. Reg. Limit: 150. Sponsor, contact: Cook County Graduate School of Medicine, 707 S. Wood St., Chicago, 60612. Attn: Robert J. Baker, M.D., Dean. Telephone: (312) 733-2800.

**SPEC. REVIEW COURSE IN INTERNAL MEDICINE, CERTIFYING (PREP. FOR BOARD)**  
For: Internists. Lecture, May 1 and May 15, 1:00 pm—One week. Cook County Graduate School of Medicine, Chicago. Speaker: Sheldon S. Waldstein, M.D. (Coordinator). CME Credit: 64 hrs. AMA Cat. 1. Fee: \$250. Reg. Limit: 550. Sponsor, contact: Cook County Graduate School of Medicine, 707 S. Wood St., Chicago, 60612. Attn: Robert J. Baker, M.D., Dean. Telephone: (312) 733-2800.

### Musculoskeletal Trauma

**MUSCULOSKELETAL TRAUMA**  
For: All physicians. Clinical program on Trauma. May 12, 8:00-10:00 pm. John B. Murphy Auditorium, 50 East Erie St., Chicago. CME Credit: 2 hrs. AMA Cat. 1. AAFP Elective. Fee: None. Sponsor, contact: Chicago Committee on Trauma of the American College of Surgeons, 11255 W. 74th St., La Grange, IL 60525. Attn: Mrs. Lillian Hata. Telephone: (312) 246-3130 or 452-8586. Co-sponsor: Rush-Presbyterian-St. Luke's Hospital.

## OB-GYN SPECIALTY REVIEW COURSE IN OBSTETRICS & GYNECOLOGY

For: Gynecologists and Obstetricians. Lecture, May 16, 9:00 am—two weeks. Cook County Graduate School of Medicine, Chicago. Speaker: John G. Masterson, M.D. (Coordinator). CME Credit: 63 hrs. AMA Cat. 1. Fee: \$375. Reg. Limit: 125. Sponsor, contact: Cook County Graduate School of Medicine, 707 S. Wood St., Chicago, 60612. Attn: Robert J. Baker, M.D., Dean. Telephone: (312) 733-2800.

### Pain Management

**CURRENT CONCEPTS IN PAIN MANAGEMENT**  
For: Physicians and Allied Health Professionals. Symposium, May 13-14 (8:00 am-5:45 pm). Ambassador West Hotel, Chicago. Speaker: Eugene J. Rogers, M.D., F.A.C.P. CME Credit: 16 hrs. AMA Cat. 1. Fee: \$100. Reg. Limit: 150. Reg. Deadline: March 15. Sponsor, contact: Chicago Medical School, Dept. Rehabilitation Medicine, 2020 W. Ogden Ave., Chicago, 60612. Attn: Eugene J. Rogers, M.D., F.A.C.P. Telephone: (312) 226-4100 ext. 350. Co-sponsor: Veterans Administration Hospital at N. Chicago.

### Psychiatry

**GROUP PSYCHOTHERAPY AND THE "NEW" PSYCHOTHERAPISTS**  
For: Mental health care professionals. Lecture, May 18, 1:00-4:00 pm. Riverside Hospital, Forest Park. Speaker: Max Rosenbaum, Ph.D., Author of "Intensive Group Experiences". CME Credit: 3 hrs. AMA Cat. 1. Fee: \$30. Reg. Limit: 200. Reg. Deadline: Reservations 7/71-7000 ext. 342. Sponsor, contact: Riverside Hospital, 8311 West Roosevelt Road, Forest Park, IL 60130. Attn: John Pontarelli. Telephone: (312) 771-7000 ext. 305.

**QUEST FOR PURPOSE IN PSYCHIC RESEARCH**  
For: Psychiatrists. Distinguished lecture series, May 18, 8:00 pm. Passavant Hospital, Chicago. Speaker: Stanley R. Dean, M.D., Stanley R. Dean Fund for Cat. Fee: None. Sponsor, contact: Institute of Research in Psychiatry. CME Credit: 1½ hrs. AMA Psychiatry, Northwestern University Medical School, 320 East Huron, Chicago, 60611. Attn: Jeanne Smith. Telephone: (312) 643-8058.

### Radiology

**REFRESHER COURSE IN RADIATION SCIENCE**  
For: Radiologists. Lecture, May 16, 8:00 am—7 days. Cook County Graduate School of Medicine, Chicago. Speaker: Theodore Fields, M.S. (Coordinator). CME Credit: 60 hrs. AMA Cat. 1. Fee: \$375. Reg. Limit: 75. Sponsor, contact: Cook County Graduate School of Medicine, 707 S. Wood St., Chicago, 60612. Attn: Robert J. Baker, M.D., Dean. Telephone: (312) 733-2800.

**ADVANCES IN SURGERY**  
For: Surgeons. Lecture, May 9, 8:00 am—one week. Cook County Graduate School of Medicine, Chicago. Speaker: Robert J. Baker, M.D. (Coordinator). CME Credit: 40 hrs. AMA Cat. 1. Fee: \$200. Reg. Limit: 60. Sponsor, contact: Cook County Graduate School of Medicine, 707 S. Wood St., Chicago, 60612. Attn: Robert J. Baker, M.D., Dean. Telephone: (312) 733-2800.

### Trauma

**21st ANNUAL POSTGRADUATE COURSE ON FRACTURES AND OTHER TRAUMA**  
For: Orthopaedic surgeons, general surgeons, general physicians. 3½ day event (annually), May 11-13, 7:30am-5:00pm and May 14, 7:30am-noon. Sheraton-Chicago Hotel. Speaker: C. McColister Everts, M.D., Rochester, NY. CME Credit: 28 hrs. AMA Category 1; AAFP Elective. Fee: \$165 (for residents, interns and allied health professions)—\$55.00 with letter from

Chief of Service). Sponsor, contact: Chicago Committee on Trauma of the American College of Surgeons. Attn: Ralph T. Lidger, M.D., c/o American College of Surgeons, 55 E. Erie St., Chicago, IL 60611. Telephone: (312) 392-4320.

## JUNE

### Cardiology

**ADVANCED CARDIOLOGY**  
For: Cardiologists. Lecture, June 6 (one week), 8:30 am, Cook County Graduate School of Medicine, Chicago. Speaker: Kenneth Rosen, M.D. (Coordinator). Fee: \$200. CME Credit: 30 hrs. AMA Cat. 1. Reg. Limit: 35. Sponsor, contact: Cook County Graduate School of Medicine, 707 S. Wood St., Chicago, IL 60612. Attn: Robert Baker, M.D., Dean. Telephone: (312) 733-2800.

### Family Medicine

**NORTHERN MICHIGAN SUMMER CONFERENCE**  
For: Family Physicians, Internists, Pediatricians. 5-day workshop, June 20-24, Shanty Creek Lodge, Bellaire, Michigan. CME Credit: AAFP Elective; AMA Cat. 1. AOA. Fee: To be determined. Sponsor, contact: Office of Continuing Education, Dept. of PGM/HPE, Towles Center, Univ. of Mich. Medical Center, Ann Arbor, MI 48109. Attn: Bette Armbruster. Telephone: (313) 763-0081.

### Hematology

**BLOOD BANKING FOR MEDICAL TECHNOLOGISTS**  
For: Medical Technologists. 2-day workshop, June 2-3, Towles Center, MI. CME Credit: AAFP Elective; AMA Cat. 1. CEU credits. Fee: To be determined. Sponsor, contact: Office of Continuing Education, Dept. of PGM/HPE, Towles Center, Univ. of Michigan Medical Center, Ann Arbor, MI 48109. Attn: Bette Armbruster. Telephone: (313) 763-0081. Co-sponsor: MABBS-NMST.

### Pulmonary Disease

**PULMONARY DISEASE WORKSHOP**  
For: Family Physicians, Internists. 3-day workshop, June 8-10, Towles Center, MI. CME Credit: AAFP Prescribed; AMA Cat. 1. Fee: To be determined. Sponsor, contact: Office of Continuing Education, Dept. of PGM/HPE, Towles Center, Univ. of Mich. Medical Center, Ann Arbor, MI 48109. Attn: Bette Armbruster. Telephone: (313) 763-0081. Co-sponsor: Michigan Academy of Family Physicians.

### Radiology

**RADIATION ONCOLOGY**  
For: Radiologists. Lecture, June 1 (3½ days), 8:00am, Cook County Graduate School of Medicine, Chicago. Speaker: Walid A. Hindo, M.D. (Coordinator). CME Credit: 34 hrs. AMA Cat. 1. Fee: \$200. Reg. Limit: 75. Sponsor, contact: Cook County Graduate School of Medicine, 707 S. Wood St., Chicago, IL 60612. Attn: Robert J. Baker, M.D., Dean. Telephone: (312) 733-2800.

### Surgery

**MANAGEMENT OF COMPLICATIONS IN SURGERY**  
For: Surgeons. Lecture, June 6 (4 days), 8:00am, Cook County Graduate School of Medicine, Chicago. Speaker: Robert J. Baker, M.D. (Coordinator). CME Credit: 28 hrs. AMA Cat. 1. Fee: \$175. Reg. Limit: 55. Sponsor, contact: Cook County Graduate School of Medicine, 707 S. Wood St., Chicago, IL 60612. Attn: Robert J. Baker, M.D., Dean. Telephone: (312) 733-2800.

## CME Planning Aids

ICCMC continually develops a variety of "how-to" material for CME Planners—DME's, program chairmen of hospitals and medical societies (both specialty and geographic), and others. All items are FREE to Illinois physicians and CME sponsors.

To learn what's currently available, request the "CME Planning Aids Order Form"; write or call . . .

Illinois Council/CME  
55 E. Monroe St., Suite 3510  
Chicago, IL 60603  
(312) 236-6110

## Have You Seen The New Illinois Mandatory CME Law?

In November, 1975, the Illinois Legislature passed a law requiring continuing medical education for relicensure. The law will be administered by the State Department of Registration and Education. FREE copies of the law are available; write or call . . .

Illinois Council/CME  
55 East Monroe St., Suite 3510  
Chicago, IL 60603  
(312) 236-6110

Blue Cross®  
Blue Shield®



# REPORT

## FOR *Illinois Physicians*

### Changes in Wrigley Company Account



Several adjustments have been made to the William Wrigley Jr. Company Blue Cross and Blue Shield health protection program (Group 80002) effective April 1, 1977 including improvements in the scope of benefits and transfer of a portion of the group to our Central Certification system.

Improvements in the contract include the change to the Blue Shield payment basis of 80% Usual and Customary charges of physicians for covered services (from reimbursement on a limited Indemnity basis); outpatient diagnostic X-ray and laboratory services in benefit up to \$250 combined Blue Cross and Blue Shield maximum per person, per calendar year; and a contract addition that includes medical emergencies if treatment is rendered within 72 hours of the onset of a sudden and serious illness.

Employees and dependents are protected by a Comprehensive Blue Cross certificate that offers covered services up to 120 days, including maternity, whenever care is needed in a Blue Cross member hospital or noncontracting hospital anywhere in the United States.

The administrative change involved the transfer of approximately 350 employees from Group #80002 in branch and field locations to a newly designated Central Certification Group with the identification number "WWY 121". New-type Central Certification Membership Identification cards will be issued to these subscribers. In place of their subscriber number, members will use their Social Security number, after the Group Number "WWY 121" for identification. (Sample of new card is shown).

When submitting a Blue Shield Physician's Ser-

		Blue Cross® Blue Shield®	
John Doe			
Identification No.		WWY-123-456-789	
Group No. WWY121	BS Plan Code 621	BC Plan Code 121	
F-CSM	4/1/77	4/1/77	
Wm. Wrigley Jr. Company			

vice Report form, please enter the Group Number "WWY 121" followed by the employee's Social Security Number exactly as it appears on the card. Send the report to us—Health Care Service Corporation, 233 North Michigan Avenue, Chicago, Ill. 60601.

(Note: The remaining members of Group #80002 will be substituting the employee Social Security number for the standards 5-digit subscriber number, effective April 1st.)

The Chicago-based Blue Cross and Blue Shield Plan is the Home Plan for the William Wrigley Jr. Company national account. The account groups have a combined enrollment of approximately 2,000 members in Illinois and another 1,300 out-of-state in California, Georgia and New Jersey.

Your assistance in recognizing and accepting the employees' distinctive identification cards and following our claim filing procedure will be appreciated. It will help us be of better service to you and to our members. Thank you for your cooperation.

### New Westinghouse Benefits

Effective April 1, 1977 approximately 3,000 Westinghouse Electric Corporation employees in Illinois have the protection of a Comprehensive Blue Cross Central Certification program. Blue Shield benefits, however, are limited. Most of the employees' medical-surgical benefits are covered in a program administered by another insurance company. Four physician-billed benefits are eligible for Blue Shield payment:

- A \$25 maximum medical-surgical fee for emergency care provided within 72 hours of the onset of the emer-

gency, in the outpatient department of a hospital only;

- Physician charges for the administration of anesthesia in a hospital, provided the physician is not salaried by the hospital;

- Pathology and radiology services on a hospital inpatient basis, provided the physician is not salaried by the hospital.

When submitting charges for any of the above services on the Blue Shield Physician's Service Report form, enter the employee's Group Number WXB-363 and his Social Security Number on the claim form. Both numbers are required to process the claim. Please send the claim to Health Care Service Corporation for payment.

## ASK BLUE SHIELD . . . ABOUT MEDICARE

### "Government in the Sunshine Act"

On March 12, 1977, the "Government in the Sunshine Act" became effective. This means that the Department of Health, Education and Welfare can no longer deny requests for information by involving certain sections of the Freedom of Information Act and the Social Security Act which specifically exempts from disclosure information about individuals in Department records.

A major effect of the Sunshine Act will be the public disclosure of certain information about physicians and other suppliers of services and items under Medicare. Such information as customary charges or amount of Medicare program payments may now be disclosed to *anyone who requests this information in writing.*

Effective March 12, 1977, the regional offices of the Social Security Administration may release the following information about individual physicians and other suppliers of services, as well as about incorporated physicians, groups of physicians and independent laboratories:

Name of physician;  
Business address;  
Specialty of physician;

Total Medicare payments, including both assigned and non-assigned amounts made both to physicians or other suppliers directly, and to patients themselves for physicians' or suppliers' services.

There should be no separate breakdown of payments for assigned claims and non-assigned claims, unless this information is specifically requested, according to the Bureau of Health Insurance. Inquiries as to how Medicare reimbursement was determined in specific claims may also be disclosed.

Medicare Part B carriers will continue to refuse to create lists which show, for example, all physicians in a given area who charge a given amount or less for a specific service.

The Medicare carrier may continue to furnish a physician with a copy of his own customary charges free of charge as long as this request is in writing.

### COVERAGE OF COMPUTERIZED TOMOGRAPHY

Medicare coverage of computerized tomography (C.T.) is limited to examinations of the head only which are consistent with the patient's diagnosis and symptoms. It is expected that a less costly means of establishing a diagnosis and/or identifying the etiology was attempted prior to performing a C.T. examination. Use of either the "general pur-

pose" whole (full) body or the "dedication" head (brain) C.T. scanners to examine the head only may be covered. The following models of C.T. scanners have been approved for use by the Bureau of Health Insurance:

Manufacturer	Model
EMI Medical, Inc.	A or CT-1000 CT-5000 CT-5005 CT-N 2
General Electric *Neuroscan, Inc. Ohio-Nuclear, Inc. (Technicare Corp.)	301 or Delta-Scan 25 300 or Delta-Scan 50
Pfizer	ACTA 0100
Snytex	S-60-1A

\*Identical to the General Electric CT-N.

Bills submitted to the Part B Medicare carrier for C.T. scans must include (1) symptoms or diagnosis necessitating the scan; (2) the area of the body examined; and (3) the model of the C.T. scanner used.

### Changes in Laboratory Certification

Notice was received from the Bureau of Health Insurance, Social Security Administration, concerning new participation or change in certification of laboratories in the Medicare program:

#### Approved for participation:

Diagnostic Scanning Laboratory  
6740 West Dempster  
Morton Grove, Ill. 60053  
Provider Number: 14-8324  
Effective Date: December 22, 1976

Scientific Medical Laboratory  
3824 North Ashland Ave.  
Chicago, Ill. 60013  
Provider Number: 14-8362  
Effective Date: December 29, 1976

Advanced Medical Laboratories, Inc.  
5457 West Chicago Ave.  
Chicago, Ill. 60651  
Provider Number: 14-8325  
Effective Date: November 16, 1976

Ligo Laboratory, Inc.  
1812 East 87th Street  
Chicago, Ill. 60617  
Provider Number: 14-8321  
Effective Date: September 3, 1976



# NEW ENSURE® PLUS

## High Calorie Liquid Nutrition.

## More Nutrition in Less Volume.



Certain clinical conditions, major burns, severe trauma and multiple fractures, for example, frequently impose calorie and nutrient demands that are often difficult to satisfy with standard one-Calorie-per-ml liquid feedings. ENSURE PLUS High Calorie Liquid Nutrition is intended for use when extra calories and higher concentrations of protein and other nutrients are needed to achieve a required calorie intake in a limited volume.



When utilized to provide total nutrition, orally or by gavage tube, ENSURE PLUS can deliver the high-calorie intakes required by severely ill or traumatized patients who are nutritionally depleted, and yet reduce the potential for problems often associated with large-volume intakes. As a dietary supplement, ENSURE PLUS can supply extra calories and protein for patients unable or unwilling to consume adequate nutrition.

- **1500 Calories per liter**  
caloric density is 50% greater than available with most liquid feedings... reduces volume of intake necessary to meet caloric needs of debilitated patients
- **55 grams of protein per liter**  
designed to compensate for the increased protein requirements associated with acute stress or chronic malnutrition
- **Balanced caloric distribution**  
ample carbohydrate and fat are provided to spare protein for tissue synthesis and repair... appropriate calorie/nitrogen ratio permits the efficient utilization of protein
- **Lactose-free**  
will not contribute to lactose-associated diarrhea
- **Convenient, ready-to-use liquid**  
available in E-Z Open 8 fl oz cans (Vanilla)... additional flavors (Orange, Strawberry, Pecan, Lemon, Cherry) are available when Vari-Flavors® Flavor Packs are mixed with Ensure Plus

**ROSS LABORATORIES**  
COLUMBUS, OHIO 43216  
Division of Abbott Laboratories, USA  
Makers of Ensure® Liquid Nutrition  
and Polydose® Glucose Polymers



# *Abstracts of Board Actions*

February 5-6, 1977

Chicago

*These abstracts are published so that members of the Illinois State Medical Society may keep advised of the actions of the Board of Trustees. It covers only major actions and is not intended as a detailed report. Full minutes of the meetings are available upon any member's request to the headquarters office of the ISMS.*

## **National Health Insurance**

The House of Delegates will be asked to clarify the society's official position on national health insurance legislation when it meets in April. The position remains in doubt because: (1) The House of Delegates last November voted to oppose "all governmentally-mandated NHI plans thus far proposed;" (2) The AMA House last December supported an association-sponsored NHI bill; and (3) ISMS policy states that "actions of the AMA House of Delegates are binding upon its membership at all levels."

Although the policy statement—which is to be reviewed by the Policy Committee—apparently binds ISMS to the AMA position, the Board noted that support of an NHI bill would violate a strong directive from the ISMS House. The conflict also forced the Board to postpone implementation of a public relations campaign ordered by the ISMS House of Delegates in November to alert the public to the drift toward a national health service.

Also tabled was a recommendation of the Council on Social and Medical Services that ISMS develop an educational program to promote AMA guidelines for a national health policy.

## **ICCME Financing**

The Board referred to a newly-created ISMS-ICCME Liaison Committee ICCME's request for continued funding from dues normally given to AMA-ERF. The committee was directed to study: (1) ICCME's long-range goals and plans for financing; and (2) A recommendation to process the annual ISMS allocation to ICCME on a zero based budget with no accumulated surplus. In a related action, however, the Board approved a request from ICCME President Dr. William Lees, that the organization be allowed to keep the presently existing surplus.

## **Budget and Finances**

The Board adopted a 1977 operating budget of \$1,578,573, with an anticipated surplus of \$2,205 and approved:

- A. Per diem payments to ISMS officers and trustees for the one-day board meetings held prior to the sessions of the annual and interim sessions of the House of Delegates.
- B. Transfer to the Equipment Replacement Fund of some \$11,478 which was originally budgeted for the Reserve Fund.
- C. Allocation to the Equipment Replacement Fund of any ISMS accumulated surplus (Unappropriated Fund Balance at Dec. 31, 1976) exceeding \$995.
- D. Transfer of any year end surplus in the appropriated Student, Intern & Resident Fund to the unappropriated Fund.
- E. A 4.8% cost of living disbursement for staff based on the Consumer Price Index, which reflected a similar increase in the cost of living for the 12-month period ended Oct. 31, 1976.
- F. A \$500 grant to the American Association of Medical Society Executives for 1977 provided AAMSE membership is limited to executives of official medical society organizations.

## **Appointments and Nominations**

The following appointments and nominations were ratified:

- A. Dr. Joseph Lloyd D'Silva, Chicago, appointed to the ISMS-INA Joint Practice Committee, replacing Dr. Bernard Adelson.

*(Continued on page 280)*

# If your angina patient\* isn't having 3 out of 4 better days than usual... try Cardilate® (ERYTHRITYL TETRANITRATE)

\*Please note: unstable angina patients may be refractory to all long-acting nitrates

**INDICATIONS:** For the prophylaxis and long-term treatment of patients with frequent or recurrent anginal pain and reduced exercise tolerance associated with angina pectoris, rather than for the treatment of the acute attack of angina pectoris, since its onset of action is somewhat slower than that of nitroglycerin.

**PRECAUTIONS:** As with other effective nitrates, some fall in blood pressure may occur with large doses.

Caution should be observed in administering the drug to patients with a history of recent cerebral hemorrhage, because of the vasodilatation which occurs in the area. Although therapy permits more normal activity, the patient should not be allowed to misinterpret freedom from anginal attacks as a signal to drop all restrictions.

**SIDE EFFECTS:** No serious side effects have been reported. In sublingual therapy a tingling sensation (like that of nitroglycerin) may sometimes be noted at the point of tablet contact with the mucous membrane. If objectionable, this may be mitigated by placing the tablet in the buccal pouch. As with nitroglycerin or other effective nitrites, temporary vascular headache may occur during the first few days of therapy. This can be controlled by temporary dosage reduction in order to allow adjustment of the cerebral hemodynamics to the initial marked cerebral vasodilatation. These headaches usually disappear within one week of continuous therapy but may be minimized by the administration of analgesics.

Mild gastrointestinal disturbances occur occasionally with larger doses and may be controlled by reducing the dose temporarily.

**SUPPLIED:** 10 mg chewable tablets, bottle of 100. Also 5, 10 and 15 mg scored tablets in bottles of 100. 10 mg scored tablets also supplied in bottle of 1,000.

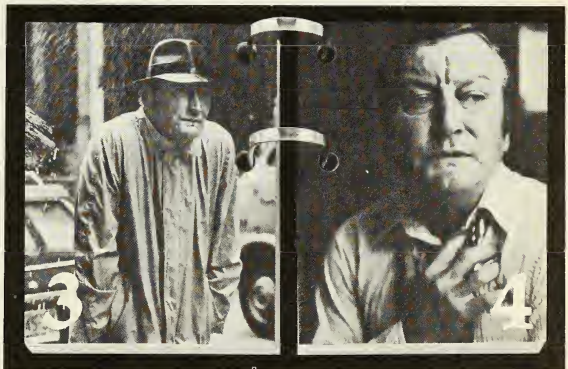
Also available: Cardilate® P brand Erythryl Tetranitrate with Phenobarbital\* (\*Warning: may be habit-forming).

1. Russek HI: AM J M Sc 239 478, 1960



**"Pain days" significantly reduced with Cardilate®** (erythryl tetranitrate) in 48-patient study.<sup>1</sup> Patients on placebo experienced same pain as usual or increased pain 2 days out of 3... compared to 1 day out of 4 while on Cardilate.

**Rapid-acting chewable tablets** (10mg) preferred by many patients. Should be given before anticipated periods of stress to produce an action within 5 minutes and lasting up to 2 hours. Sublingual tablets also available.

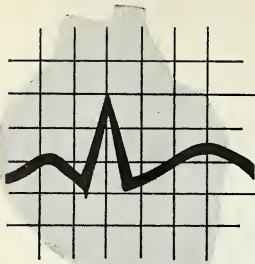


**Effective prophylaxis against attacks;** increases exercise tolerance. Serious side effects have not been reported in 20 years' clinical use.

**Cardilate can save patients money;** is less expensive than many popular long-acting nitrates. 20% to 30% savings not uncommon...also helps reduce need for nitroglycerin.



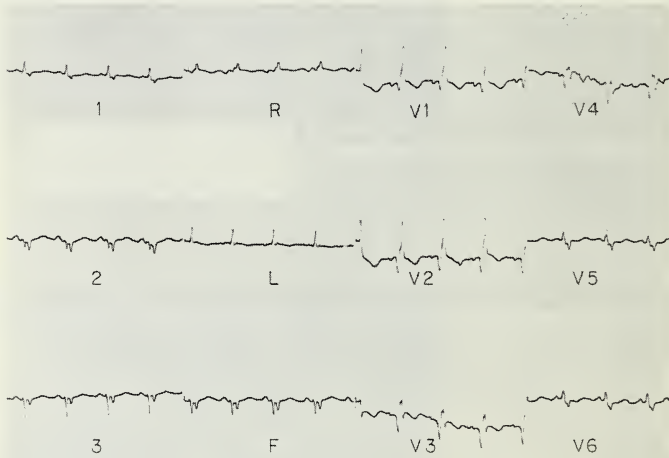
Burroughs Wellcome Co.  
Research Triangle Park  
North Carolina 27709



## ekg of the month

JOHN R. TOBIN, JR., M.S., M.D., RIMGAUDAS NEMICKAS, M.D.,  
PATRICK J. SCANLON, M.D., JOHN F. MORAN, M.S., M.D.,  
SARAH JOHNSON, M.D., and ROLF M. GUNNAR, M.S., M.D./  
Section of Cardiology, Department of Medicine,  
Loyola University Stritch School of Medicine

This patient is a 54-year-old man who had sustained a myocardial infarction eight weeks prior to this admission. His infarction was complicated and he was only out of the hospital four weeks at this time. He entered the emergency service with severe dyspnea. Physical examination demonstrated a tachycardia with a summation gallop, a blood pressure of 100/70 mmHg, distended neck veins, and bilateral moist rales halfway up the scapulae on examination of the lungs. A chest X-ray was compatible with pulmonary edema and showed cardiomegaly. A rhythm strip demonstrated sinus rhythm. The patient was treated with nasal oxygen, morphine sulfate, an additional dose of intravenous digoxin and furosemide. He improved somewhat and a 12 lead ECG was obtained.



### Questions:

#### 1. The ECG shows:

- Left axis deviation.
- An extensive anteroseptal myocardial infarction.
- Complete right bundle branch block.
- Ventricular tachycardia.
- Right ventricular hypertrophy.

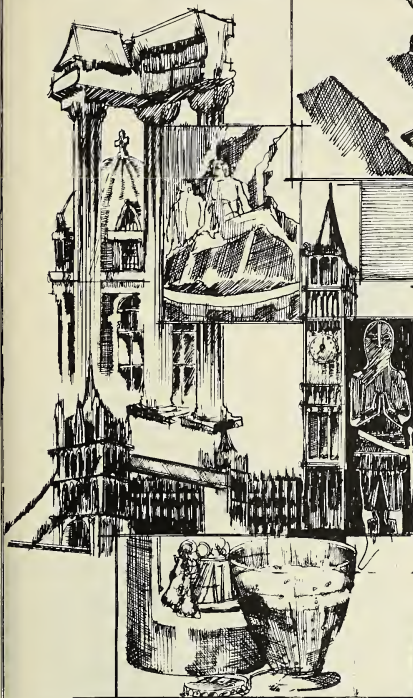
#### 2. Further management of this patient would include:

- Coronary care unit monitoring.
- Serum enzymes CPK, SGOT, and LDH to rule out another infarction.
- Serial ECG's.
- Pacemaker therapy.
- Intravenous norepinephrine or dopamine.

(Answers on page 271)



## DISCOVER THE GLORY THAT IS ROME



## THE MAGNIFICENCE OF LONDON



Two of the world's most incomparable cities are within your reach in 1977. You'll have 10 days in which to explore and experience the excitement of both worlds. **Rome**, the "Eternal City" with its endlessly fascinating museums, art galleries, churches and palaces, Roman gardens and fountains. **Rome**, the city where "la dolce vita" began and shows no sign of ending.

**London** a kaleidoscopic mixture of architecture centuries old, mixed well with the modern look of today . . . Piccadilly Circus, Hyde Park, Carnaby Street, Soho, St. Paul's Cathedral, Buckingham Palace — all names you've read or heard.

And, for the first time, we are able to make a special limited "air fare only" offering at a price considerably lower than regular economy air fares.

Why not plan, now, to make all the sights and sounds of Rome and London more than what you've read or heard. Make them both a part of your life.

Get all the details by sending the coupon below.

Ten Days departing Chicago, October 14-23, 1977.

## ROME·LONDON DISCOVERY

Land/Air Package \$898  
Air only Package \$529

Send to:  
Illinois State Medical Society  
55 E. Monroe Street  
Suite 3510  
Chicago, Illinois 60603

Please rush me a Rome-London Discovery Brochure

NAME \_\_\_\_\_

HOME ADDRESS \_\_\_\_\_

CITY/STATE/ZIP \_\_\_\_\_



Deluxe nine story medical building, adjacent to Columbus Hospital and Lincoln Park, has suites available for immediate occupancy. Inside parking & full cleaning services. Free moving expenses & two months free rent available

**DOCTORS WANTED**  
Suites 350 to 600 sq. ft. from \$8.50 per sq. ft.

**PARK PROFESSIONAL BUILDING**

467 W. Deming Pl.  
Chicago, Ill.  
641-7000

McKey & Poague, Inc., Agents

**OBITUARIES**

\*Ferguson, Fred Grant, Decatur, died February 17 at the age of 78. Doctor Ferguson was a 1928 graduate of the University of Illinois.

\*Gamble, Richard C., Sedona, Arizona, formerly of Park Ridge, died December 23 at the age of 81. Doctor Gamble was a 1919 graduate of Rush Medical School.

\*Galloway, Thomas C., Evanston, died February 24 at the age of 89. Doctor Galloway was a 1912 graduate of Rush Medical School.

\*Helfers, Edward C., Glenview, died February 26 at the age of 80. Doctor Helfers was a 1921 graduate of Loyola University.

\*Hrdina, Joseph L., McHenry, died February 16 at the age of 69. Doctor Hrdina was a 1934 graduate of the University of Illinois.

\*Leo, Joseph E., Chicago, died February 16 at the age of 82. Doctor Leo was a 1919 graduate of the Stritch School of Medicine.

\*Sanford, Heyworth N., New Haven, Connecticut, formerly of Chicago, died February 10 at the age of 82. Doctor Sanford was a 1925 graduate of Rush Medical School.

\*Indicates ISMS member.

\*Indicates member of the ISMS Fifty Year Club.

**CORRECTION:**

The March issue of IMJ included two factual errors in the obituary for Vernon R. DeYoung, M.D., Chicago, who died on January 24, 1977. Doctor DeYoung, a University of Chicago graduate, died at the age of 71. We regret this error.

**Clinics for Crippled Children  
Listed for May**

Thirty-three clinics for Illinois physically handicapped children have been scheduled for May by the University of Illinois, Division of Services for Crippled Children. The Division will count twenty-three general clinics providing diagnostic, orthopedic, pediatric, speech and hearing examination, along with medical social and nursing services. There will be eight special clinics for children with cardiac conditions and two for children with cerebral palsy. Any private physician may refer to or bring to a convenient clinic any child or children for whom he may want examination or consultative services.

- May 4 Mt. Vernon, Good Samaritan Hospital
- May 4 Hinsdale, Hinsdale Hospital
- May 5 Sterling, Community General Hospital
- May 5 Pittsfield, Illini Community Hospital
- May 5 Effingham, St. Anthony Memorial Hospital
- May 5 Lake County Cardiac, Victory Memorial Hospital
- May 6 Division Cardiac, U. of I. at the Medical Center
- May 9 Peoria Cardiac, St. Francis Hospital
- May 10 E. St. Louis, Christian Welfare Hospital
- May 10 Peoria, St. Francis Hospital
- May 11 Champaign-Urbana, McKinley Hospital
- May 11 Chicago Heights General, St. James Hospital
- May 11 Joliet, St. Joseph's Hospital
- May 12 Springfield, St. John's Hospital
- May 12 Macomb, McDonough District Hospital
- May 13 Chicago Heights Cardiac, St. James Hospital
- May 16 Maywood, Loyola Medical Center
- May 17 Belleville, St. Elizabeth's Hospital
- May 17 Rock Island, Moline Public Hospital
- May 17 Decatur, Decatur Memorial Hospital
- May 18 Anna, Union County Hospital
- May 18 Centralia, St. Mary's Hospital
- May 18 Evergreen Park, Little Company of Mary Hospital
- May 19 Rockford, Rockford Memorial Hospital
- May 19 Elmhurst Cardiac, Memorial Hospital of DuPage County
- May 23 Peoria Cardiac, St. Francis Hospital
- May 24 Peoria, St. Francis Hospital
- May 24 Park Ridge Cardiac, Lutheran General Hospital
- May 25 Springfield Pediatric-Neurology, St. John's Hospital
- May 25 Rock Island Cerebral Palsy, Foundation for Crippled Children & Adults
- May 25 Chicago Heights General, St. James Hospital
- May 25 Elgin, Sherman Hospital
- May 27 Chicago Heights Cardiac, St. James Hospital

The Division of Services for Crippled Children is the official state agency established to provide medical, surgical, corrective and other services and facilities for diagnosis, hospitalization and after-care for children with crippling conditions or who are suffering from conditions that may lead to crippling. In carrying on its program, the Division works cooperatively with local medical societies, hospitals, the Illinois Children's Hospital-School, civic and fraternal clubs, visiting nurse association, local, social and welfare agencies, local chapters of the National Foundation and other interested groups. In all cases the work of the Division is intended to extend and supplement, not supplant activities of other agencies, either public or private, state or local, carried on in behalf of crippled children.

# THERE ARE A LOT OF PEOPLE GETTING BETWEEN YOU AND YOUR PATIENT.

Medicine today is in the spotlight, subjected to all kinds of scrutiny. Your control over patient therapy is being monitored, judged and occasionally abrogated, sometimes by unknown third parties.

The worry is that in the wake of this focus, the relationship between you and your patient will be weakened, without offsetting benefits. Consider three examples:

**Drug substitution** In most states, pharmacy laws, regulations or professional custom stipulate that your non-generic prescriptions be filled with the precise products you prescribe. But in the last five years, a dozen or more State laws have been changed, permitting the pharmacist in most cases to select a product of the same generic drug to fill any prescription.

Ironically, this dilution of physician control has taken place against a background of growing evidence that purportedly equivalent drug products may be inequivalent, since neither present drug standards nor their enforcement are optimal. In fact, the FDA itself says it has not enforced the same standards for hundreds of "follow-on" products that it had applied to the original NDA approvals. Thus physician control over patient therapy is being eroded with a risk that patients may be exposed to drugs of uncertain quality.

The major advertised claim for substitution is reduced prescription prices for consumers. Yet no documentation of any significant savings has been produced.

**MAC** Maximum Allowable Cost, MAC for short, is a Federal regulation designed to cut the Government's drug bill by setting price ceilings for drugs dispensed to Medicare and Medicaid patients. Unless the prescriber certifies on the prescription that a particular product is medically necessary, the Government intends to pay only for the cost of the lowest-priced, purportedly-equivalent,

generally-available product. The effect of the program may be that elderly and indigent patients will be restricted to products which someone in Washington believes are priced right. Practicing doctors will have little to say about administration of the program, since Government will have absolute authority to make its choices stick.

**The drug lag** The future of drug and device research depends upon a scientific and regulatory environment that encourages therapeutic innovations. The American pharmaceutical industry annually is spending more than \$1 billion of its own funds and evaluating more than 1,200 investigational compounds in clinical research. Disease targets include cancer, atherosclerosis, viruses and central nervous system disorders, among others. But there is a major barrier to the flow of new drugs to your patients: The cost of the research is more than ten times what it was, per product, in 1962; and whereas governmental clearance of new drug applications took six months then, it commonly consumes two years now.

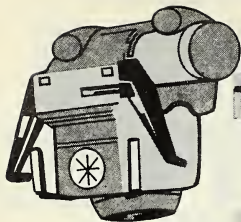
The FDA needs adequate time, of course, to consider data. But it is equally clear that the present approval process contributes to needless delay of needed therapy. That's why the increased efficiency of the drug approval process is vital to all our futures.

If these issues concern you, we suggest that you make your voice heard—among your colleagues and your representatives in State legislatures and in Washington.

It could make a difference in your practice tomorrow.



Pharmaceutical Manufacturers Association  
1155 Fifteenth Street, N.W., Washington, D.C. 20005



## the view box

LEON LOVE, M.D./CHAIRMAN/DEPARTMENT OF RADIOLOGY  
LOYOLA UNIVERSITY STRITCH SCHOOL OF MEDICINE

This patient was a 44-year-old male who complained of a sudden onset of fever and right flank pain with positive right-sided Murphy punch on physical examination. The urine specimen was reported as normal. An IVP was done on 4-22-76 and repeat study on 6-1-76.



Figure 1



Figure 2

**What's your diagnosis?**

*(Answers on page 291)*



# I M J

Illinois Medical Journal

Vol. 151, No. 4, April, 1977

## Nonfunctional Retroperitoneal Extra-Adrenal Paraganglioma *Case Report*

By SIDNEY M. CRAIN, B.S. AND DIPANKAR MUKHOPADHYAY, M.B.B.S., F.R.C.P. (C) /BERWYN

*Extra-adrenal retroperitoneal paragangliomas occurring during childhood are very rare tumors. This report represents only the sixth such case in the literature.<sup>1,2,4-6</sup> The present report describes the occurrence of such a tumor in a ten-year-old boy.*

A ten-year-old white male was admitted for evaluation of a large palpable left sided abdominal mass. The mass was discovered during a

routine pre-school physical examination. A physical examination one year earlier revealed no palpable abdominal mass. The patient presented no symptoms or complaints and was unaware of the presence of the mass. No history of trauma to the abdomen, low back pain, abdominal pain, or any other pertinent history was elicited.

Physical examination revealed a large non-ballotable abdominal mass extending from the left costal margin to the left anterior superior iliac spine. The mass was nontender and firm to palpation. The rest of the physical examination was uneventful. Blood pressure on admission was 120/80.

Laboratory studies demonstrated a normal CBC, urinalysis, and serum amylase. A Tc-99m sulfur colloid liver scan revealed a normal liver

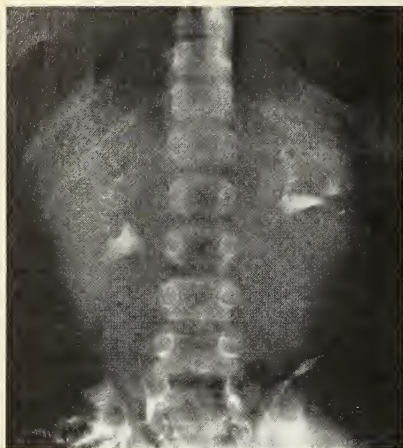
---

DIPANKAR MUKHOPADHYAY, M.D., M.B.B.S., F.R.C.P.(C), is Academic Director of Pediatrics at MacNeal Memorial Hospital in Berwyn. Dr. Mukhopadhyay also is associate professor of clinical pediatrics at the University of Illinois Abraham Lincoln School of Medicine.

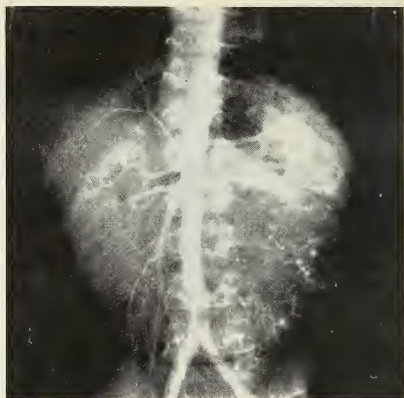
SIDNEY M. CRAIN, M.D., is a senior medical student at the University of Illinois Abraham Lincoln College of Medicine in Chicago. Dr. Lauer plans to specialize in Internal Medicine with a subspecialty in ancalogy upon the completion of his residency in June, 1977.







**Figure 1**  
IVP demonstrating upward and lateral displacement of the left ureter.



**Figure 2**  
Angiogram demonstrating encapsulated highly vascularized tumor. The blood supply appears to come from the lower intercostals, renal, and lumbar arteries.

and spleen. An IVP demonstrated a retroperitoneal mass causing upward and lateral displacement of the left ureter. The kidneys and adrenals appeared normal. (Fig. 1) An upper GI series was normal. An abdominal angiogram demonstrated a large, well encapsulated, noncalcified, highly vascularized tumor extending to the right side of the vertebral column indenting and displacing the abdominal aorta. Extensive neovascularity was noted with arteriovenous shunting. The blood supply appeared to come from the lower intercostals, renal arteries, and lumbar arteries. (Fig. 2)

At laparotomy the mass was found to be entirely retroperitoneal. Superiorly the tumor rested on the anterior surface of the pancreas, medially on the vertebral column, and inferiorly on the anterior superior iliac spine. The tumor appeared partially encapsulated and contained many tortuous varicose veins on its surface. Removal of the mass was accomplished by dissecting in a plane between it and the underlying neighboring tissues. The tumor bled extensively on removal. It was not adherent to and did not involve the pancreas, adrenals, or kidneys.

The patient became mildly hypertensive 48 hours following surgery due to hypervolemia. Blood pressure returned to normal with the re-

striction of fluids.

He is alive and well six months postoperatively and shows no signs of recurrence.

### Pathology Report

The mass appeared soft and lobulated, measured 13 x 8 x 6 cm. and weighed 225 grams. The cut surface of the tumor demonstrated a variegated appearance with cystic degeneration in the central portion. In focal areas, the tumor appeared pinkish gray but most of the tumor was yellow, suggesting the appearance of adrenals. Serial multiple sections demonstrated a moderately well encapsulated tumor mass containing blood vessels and nerve segments in the fibrous tissue capsule. Underlying tumor mass was highly vascular and was composed of polygonal cells arranged in nests and separated by delicate hyalinized vascular connective tissue trabeculae extending down from the fibrous capsule. (Fig. 3) In some areas the trabeculation was very fine and almost indistinct and the tumor cells appeared as sheets or solid areas rather than the typical pattern of nests. The individual tumor cell was polygonal with finely granular and homogeneous eosinophilic cytoplasm and fairly uniform oval vesicular nuclei. Occasional nuclei

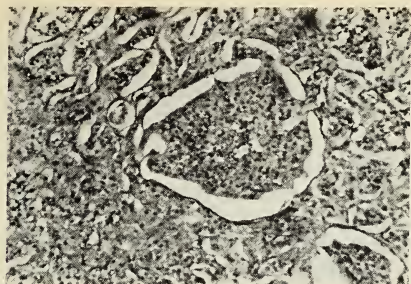


Figure 3

Photomicrograph illustrating nests of cells surrounded by stroma rich in blood vessels.

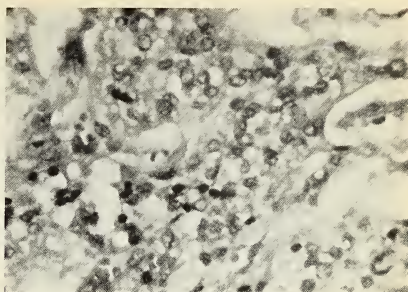


Figure 4

Photomicrograph illustrating nests of polygonal cells with finely granular or homogenous eosinophilic cytoplasm. The cells have round or oval vesicular nuclei but occasional nuclei appear shrunken and hyperchromatic. Mitotic figures are hard to find.

appeared shrunken and hyperchromatic, but mitosis were rare. (Fig. 4)

### Discussion

Nonfunctional retroperitoneal extra-adrenal paraganglioma is a rare tumor in children as evidenced by only five reported cases in English

literature. Pertinent data of these cases and the present case is summarized in Table 1. None of these patients had clinical evidence of excessive catecholamine secretion; in only one child uri-

TABLE I  
Summary of Six Patients with Retroperitoneal Extra-Adrenal Paraganglioma

	Case 1 <sup>1</sup>	Case 2 <sup>2,3</sup>	Case 3 <sup>4</sup>	Case 4 <sup>5</sup>	Case 5 <sup>6</sup>	Case 6 (present)
Age (yrs.)	9	16	16	5½	12	10
Sex	Female	Male	Female	Male	Male	Male
Race	Black	White	White	White	Unknown	White
Initial signs & symptoms and duration	Abdominal mass and pain 3 months	Abdominal pain—4 years mass—1 year	Asymptomatic mid abdominal mass 2 mos.	Grand mal seizure and hypertension 2 days	Severe low back pain 2 months	Asymptomatic abdominal mass—1 week
Catecholamine Secretion	Not done	Not done	Not done	Normal	Not done	Not done
Location	Over left Psoas muscle. Left of aorta	Overlying abdominal aorta and Inf. Vena Cava from their bifurcation to renal vessel	Overlying bifurcation of aorta and Inf. Vena Cava	Overlying Left Common Iliac vessel involving ureter	Left sided mass adjacent to vertebral bodies displacing pancreas anteriorly	Rested on pancreas medially on Vertebral Column and inferiorly on Anterior Sup. Iliac Spine
Treatment	Excision	X-ray therapy	Excision	Excision	X-ray therapy	Excision
Metastasis	None	None	None	Left kidney	Retroper. liver, lungs bones	None
Follow-up	None	7 yrs. alive	7 yrs. alive	None	Death 10 yrs.	6 months alive

nary catecholamines were measured (Case 5) and found to be normal even though the child presented with convulsion and hypertension. It was thought hypertension was of renal origin. Abdominal mass with or without pain is the most common presenting feature. Only in one patient (Case 3) an associated paraganglioma of aortic body was found seven years later. Two of the six patients had metastases. In adults surgical excision seems to be the treatment of choice. Because of the small number of cases reported, long term prognosis remains unknown. ◀

#### Acknowledgement

We thank Drs. Gerald Hancur and Ernest Hessl, Department of Surgery, for allowing us to report this patient.

#### References

1. Smetana, H. F., and Scott, W. F.: "Malignant Tumors of Nonchromaffin Paraganglia," *Milit. Surg.* 109:330-349, 1951.
2. Sessions, R. T., and Scott, H. W., Jr.: "Retroperitoneal Nonchromaffin Paraganglioma," *Amer. J. Surg.* 99:70-76, 1960.
3. Stephenson, S. E., Jr.: "Discussion," *Ann. Surg.* 159: 965-966, 1964.
4. Haber, S.: "Retroperitoneal and Mediastinal Chemo-dectoma," Case report and review of literature. *Amer. J. Roent.* 92:1029-1041, 1964.
5. Cohen, S. M. and Persky, L.: "Malignant Non-chromaffin Paraganglioma with Metastases to the Kidney," *J. of Urology* 96:122-126, 1966.
6. Olson, J. R., and Abell, M. R.: "Nonfunctional Non-chromaffin Paragangliomas of the Retroperitoneum," *Cancer* 23:1358-1367, 1969.

## LOW-COST GROUP INSURANCE ANOTHER **ISMS** MEMBERSHIP PRIVILEGE

FOR INFORMATION,  
ASSISTANCE  
& DETAILS CONTACT:

Administrators:

**PARKER, ALESHIRE & COMPANY**  
ESTABLISHED 1901  
*Insurance*

**THE GROUP DISABILITY PLAN** ● Provides up to \$1,732.00 monthly in the event of disability caused by Accident or Sickness. ● Special Guaranteed renewal feature. ● Protect your income and security.

**BUSINESS OVERHEAD EXPENSE PLAN** ● Pays your office overhead expense when disability strikes. ● Premiums are Tax Deductible. ● Pays in Addition to the Disability Plan Benefits.

**THE BASIC MAJOR MEDICAL EXPENSE PLAN** ● In or out of Hospital Benefits up to \$25,000.00 per Disability. ● Up to \$100.00 Daily Hospital Room and Board maximum. ● Subject to choice of deductible and 80% coinsurance.

**EXCESS MAJOR MEDICAL PLAN** ● Provides up to \$250,000 for Medical Expenses. ● Supplements any Basic Major Medical Plan and has a \$25,000 deductible. ● Low group rates. ● Truly catastrophic coverage.

9933 N. Lawler Avenue  
Skokie, Illinois 60076  
Phone: 312-679-1000



# Teething in Infancy

## A Part of Normal Development

HARVEY KRAVITZ, M.D., BENJAMIN EMANUEL, M.D. JOSEPH KASPER, Ph.D.  
AND ARTHUR NEYHUS, Ph.D./CHICAGO

*This material was researched in cooperation with the Department of Pediatrics, Children's Memorial Hospital, Northwestern University Medical School*

*Mothers of 110 normal infants were interviewed monthly for one year as to 17 signs associated with the eruption of the first deciduous tooth. Eleven signs were present to a statistically significant degree ( $P < .01$ ). These signs were the following: lip biting, biting objects, hand biting, stuffy nose, night crying, restlessness, diaper rash, loose stools, night cough, poor appetite and face rash. Two signs present to a statistically significant degree ( $P < .05$ ) were low grade fever and drooling. Drooling, hand biting and biting objects may be related to development rather than teething.*

Medical authorities from the time of Hippocrates and Galen down to Pare in the medieval era have believed that teething is associated with pain. The folklore of every country is replete with accounts on how to relieve painful teething. Kanner<sup>1</sup> collected a long list of diverse remedies employed by various peoples to combat pain attributed to teething. Throughout a good part of the 19th century, physicians attributed convulsions, high fevers, pneumonia, measles, meningitis, paralysis and even death to teething.



HARVEY KRAVITZ, M.D., is a practicing pediatrician affiliated with the Department of Pediatrics, Children's Memorial Hospital, Northwestern University Medical School, as well as the Department of Pediatrics, Lutheran General Hospital, Park Ridge. He is a member of the National Accident Prevention Committee of the American Academy of Pediatrics, and a member of the Child Health Committee of the National Safety Council.

BENJAMIN EMANUEL, M.D., is Chief of the Pediatrics Department at Edgewater Hospital in Chicago. At this writing, Dr. Emanuel, a specialist in pediatric nephrology, was affiliated with the Department of Pediatrics, Children's Memorial Hospital, Northwestern University Medical School.

JOSEPH KASPER, Ph.D., is now Chief Psychologist at the Hutchings Psychiatric Center in Syracuse, New York. At this writing he was affiliated with the Department of Pediatrics, Children's Memorial Hospital, Northwestern University Medical School.

ARTHUR NEYHUS, Ph.D., is an associate professor of psychology and coordinator of the Hearing Impaired Program at the University of Illinois Circle Campus. He is particularly interested in the differential diagnosis of children and adolescents who suffer from severe and profound learning problems.

At the end of the 19th century after the discovery of the bacterial agents of many of the infections, there were two opposing groups of physicians: one favoring the idea that teething caused signs and symptoms and the other who flatly disbelieved this. Forsheimer<sup>2</sup> was among those who continued to believe that teething could cause the following signs: (1) salivation, (2) crying and restlessness, (3) excessive drinking of water, (4) slight increase in temperature, (5) increased urination, (6) vomiting, (7) diarrhea, (8) coryza, (9) cough, (10) drool rash. He found that 80% of infants exhibited some of these signs.

After 1910, papers on teething as a cause of serious disease became rare. Yet a survey of European and American pediatric textbooks published after 1900 indicates that many of the authors have continued to believe that teething may produce certain signs and symptoms. In his 1912 edition, Holt<sup>3</sup> stated that 50% of infants with teething will have disturbed sleep, irritability, loss of appetite, excessive salivation, loose stools, slight elevation in temperature and a greater tendency to bite or suck their fingers.

Other authors of pediatric textbooks Abt<sup>4</sup>; Eley and Grulee<sup>5</sup>; Nelson<sup>6</sup>; and Hughes<sup>7</sup> mention at least two or three signs listed by Holt as occurring during teething in infancy. In contrast Fanconi and Walgreen<sup>8</sup> believe that the eruption of the teeth is a physiologic process causing no signs or symptoms. Many physicians have been taught this latter view in medical school.

Many dentistry texts agree, in general, that teething can be painful and produce signs and



symptoms.<sup>9,10</sup> Bunting and Hill,<sup>11</sup> in their textbook on oral pathology, mention that the eruption of the deciduous teeth is accompanied by a diversity of signs and symptoms similar to those described by Forsheimer.

Other evidence of teething being a painful process are the observations of authorities in veterinarian medicine. Muller and Glass<sup>12</sup> have reported that dogs have increased salivation, loss of appetite and distemper when their teeth erupt. Harlow<sup>13</sup>, the authority on primate behavior, states that monkeys are more hyper-active, irritable and exhibit increased biting activity when teething.

In a comprehensive study of urban infants Mindlin<sup>14</sup> has shown that teething, colds, rashes and gastrointestinal disturbances account for half of the problems that mothers report, with teething listed as the second most frequent complaint which brings a sick white infant to a physician. Schwartzman<sup>15</sup> reported that 27% of sick infant visits resulted from problems of teething.

With the exception of the studies by Seward<sup>16</sup> and Tasanen<sup>17</sup>, previous reports of the signs and symptoms of teething have not generally been subjected to a statistical analysis of carefully

gathered data.

This paper reports on a statistical study of the signs associated with the eruption of the first deciduous tooth in 110 normal infants.

## Methods

The sample consisted of 110 normal white infants (53 males and 57 females) followed in a suburban pediatric practice by routine monthly visits during the first year of life. At each visit the parent was interviewed concerning the presence or absence since the previous visit of 17 specific signs ascribed to teething, and the answers recorded on a separate questionnaire for each infant. The exact age of each infant at the time of eruption of the first deciduous tooth was also noted. These data were gathered in the form of yes/no responses to direct questions, i.e., "Has the baby been sleeping through the entire night or has there been a period of crying". From these responses the frequency of each sign was tabulated for three months, two months and one month prior to eruption of the first deciduous tooth. The number of subjects presenting each sign prior to eruption was compared with those

Month Sign First Observed  
N = 22

SIGN	1	2	3	4	5	6	7	8	9	10
HEAD ROLLING										
POOR APPETITE				*	*					
DROOLING	***		****	****						
BITING LIP			**	****	***					
BITING OBJECTS	**		****	****	**					
BITING HAND	*		****	****	**					
VOMITING					*					
STUFFY NOSE				**	****					
NIGHT CRYING				****	****					
RESTLESSNESS			*	****	****					
CONVULSIONS										
FACE RASH				***	**					
DIAPER RASH			*	*	*					
LOOSE STOOLS			*	**	***					
CONSTIPATION				*						
RECTAL TEMPERATURE 100.0°F					**					
COUGH				****	****					

Fig. 1 Month signs of teething first observed prior to or during the month of eruption of the first deciduous tooth in a group of early teething infants between four and five months of age.

presenting during the month of eruption, employing a 2x2 chi square. The sample was divided into three groups: early teethers, normal age teethers and late teethers. The number of infants presenting each sign of teething were recorded for each group.

### Results

The results are summarized in Tables 1-3 and Figures 1-3. Table 1 shows the number of infants presenting 17 signs of teething at three months, two months, one month prior to eruption and the month of eruption of the first deciduous tooth. At the time of eruption six signs were present in more than two-thirds of the subjects. These included the following: hand biting, biting objects, lip biting, drooling, restlessness and night crying. Although occurring in less than 50% of the subjects, a significant rise in frequency was noted for such signs as diaper rash, night cough, loose stools, night crying and poor appetite.

The increase in the number of infants exhibiting the signs of teething from the period three months prior to eruption to the time of eruption was found to be significant ( $P < .01$ ) for eleven

parameters. These included the following: lip biting, biting objects, hand biting, stuffy nose, night crying, restlessness, diaper rash, loose stools, night cough, face rash and poor appetite. (Table 2) Temperatures between 100.0-100.8 F. (37.7-38.2 C.) rectally and drooling were signs present at the .05 level. (Table 2)

Figures 1-3 show the number of infants presenting each of 17 signs of teething prior to and during the month of eruption of the first deciduous tooth in early teething, normal age teething and late teething groups respectively.

### Discussion

While the data in Table 2 show that 13 signs of teething are significant at the .01 or .05 level, observation of the data in Figures 1-3 reveals that drooling, biting objects and hand biting occur most frequently during the third and fifth month of life, when the early teethers, normal age teethers and late teething groups are compared. This suggests that these signs may be developmental in origin rather than related to the eruption of the first deciduous tooth as has been stated by van der Horst.<sup>18</sup>

Month Sign First Observed

N = 46

SIGN	1	2	3	4	5	6	7	8	9	10
HEAD ROLLING				*		*				
POOR APPETITE				*	**	**	*			
DROOLING	****	*****	*****	*						
BITING LIP		**	*****	*****	*		**			
BITING OBJECTS	**	*****	*****	*****	*					
BITING HAND	*	*****	*****	*****	*					
VOMITING		*		*	*	*				
STUFFY NOSE			**	****	****	****	****			
NIGHT CRYING			**	****	****	****	****			
RESTLESSNESS		**	****	****	****	****	****			
CONVULSIONS										
FACE RASH				**	****					
DIAPER RASH			*	****	**	****				
LOOSE STOOLS			*	**	****	****				
CONSTIPATION				*						
RECTAL OVER TEMPERATURE 100.0°F			**	*	*	*	****			
COUGH			**	****	****	****				

Fig. 2 Month signs of teething first observed prior to or during the month of eruption of the first deciduous tooth in a group of infants teething between six and seven months of age.

Table 1  
Number of Infants Presenting Seventeen Signs of Teething Prior to and During the  
Eruption of the First Deciduous Tooth (N=110)

Sign	No. subjects presenting sign three months prior to eruption		No. subjects presenting sign two months prior to eruption		No. subjects presenting sign one month prior to eruption		No. subjects presenting sign during the month of eruption	
	N.	%	N.	%	N.	%	N.	%
Head Rolling	1	.9	1	.9	0	0	2	1.8
Poor Appetite	2	1.8	6	5.4	12	10.9	19	17.2
Drooling	75	68.2	91	82.7	99	90.0	100	90.9
Biting Lip	31	28.1	58	52.7	82	74.5	93	84.5
Biting Objects	67	60.9	89	80.9	101	91.8	108	98.1
Biting Hand	70	63.6	91	82.7	105	95.4	108	98.1
Vomiting	1	.9	1	.9	4	3.6	5	4.5
Stuffy Nose	10	9.0	17	15.4	27	24.5	48	43.6
Night Crying	8	7.2	23	20.9	48	43.6	75	68.1
Restlessness	22	20.0	46	41.8	68	61.8	87	79.1
Convulsions	0	0	0	0	0	0	0	0
Face Rash	1	.9	4	3.6	11	10.0	17	15.4
Diaper Rash	3	2.7	11	10.0	14	12.7	29	26.3
Loose Stools	1	.9	7	6.3	19	17.2	38	34.5
Constipation	0	0	0	0	2	1.8	2	1.8
Rectal Temperature over 100.0F (37.7C)	1	.9	5	4.5	7	6.3	11	10.0
Cough	3	2.7	16	14.5	34	30.9	51	46.3

Month Sign First Observed  
N = 34

SIGN	1	2	3	4	5	6	7	8	9	10
HEAD ROLLING				*				*		
POOR APPETITE				*	*		****	*****	*	
DROOLING	***		*****	*****	*					
BITING LIP			***	*****	*****	*****	*****	*		
BITING OBJECTS	**		*****	*****	*****	*****				
BITING HAND	**		*****	*****	*****	*				
VOMITING			*		*	**				
STUFFY NOSE					**	*****	*****	*****	**	
NIGHT CRYING				**	***	*****	*****	*****	*	
RESTLESSNESS				***	*****	*****	*****	**	**	
CONVULSIONS										
FACE RASH					*	**	**	*		
DIAPER RASH						****	*****	*****		
LOOSE STOOLS						**	*****	*****	*	
CONSTIPATION								*		
RECTAL TEMPERATURE over 100.0°F					*	*	**	**		
COUGH					*	*****	*****	**	**	

Fig. 3 Month signs of teething first observed prior to or during the month of eruption of the first deciduous tooth in a group of late teething infants between eight and nine months of age.

Inspection of the data in Figures 1-3 shows that stuffy nose, night crying, restlessness, face rash, diaper rash, loose stools, cough and low grade fever are present with increased frequency in the three months prior to eruption and during the month of eruption in each of the three groups and give further evidence of their association with the teething process. Therefore, we disagree with van der Horst who has stated that teething in infancy is free of any disturbances.<sup>18</sup>

Seward<sup>16</sup> has reported a study statistically demonstrating that teething is associated with a number of disturbances. She employed a retrospective questionnaire to collect data on 18 disturbances associated with the eruption of the anterior and posterior deciduous teeth of 224 normal infants. Twelve of the disturbances which Seward has found to accompany the eruption of the primary anterior teeth are compared to 12 similar signs in our study (Table 3). Night crying and restlessness are present in the highest percentage of cases in both studies. It should be noted that Seward's data included the signs associated with the eruption of all eight anterior deciduous teeth, while our study was concerned with the signs related to the eruption of the first deciduous tooth.

Tasanen<sup>17</sup> in a controlled study of deciduous teething, concluded that teething can cause daytime restlessness, increased finger sucking, gum rubbing and drooling. He found no evidence of diarrhea, loss of appetite, rubbing of the ear or cheek, sleep disturbances or low grade fever. Tasanen did not study the association of coryza,

diaper or face rash, night cough or lip biting to the eruption of the deciduous teeth. While Tasanen had a control group, there is evidence that the control group was observed by the investigator during the day and not at night. This may be the reason night crying was not reported to be present in his study. Tasanen noted that mothers in the experimental groups who observed their infants at night did report crying to be present during the eruption of the teeth. Also Tasanen studied the eruption of all the deciduous teeth till the age of 30 months, while our study was confined to the eruption of the first deciduous tooth. This may account for the differences in our findings.

Convulsions as a result of teething did not occur in our study indicating it should be discarded forever as a sign of teething. Constipation, head rolling and vomiting were not present to a statistically significant degree.

Coughing and stuffy nose showed sharp rises in frequency and their association with the eruption of the first deciduous tooth was statistically significant. This association has been described by Bunting and Hill<sup>11</sup> and Forsheimer.<sup>2</sup> We believe these signs are produced by the dripping of excess saliva into the naso-pharynx and hypopharynx. Face rash was also present to a significant degree. The rashes are produced by the rubbing of the cheeks and mouth on the bed sheets during periods of crying and restlessness while teething. The number of infants having loose stools while cutting their first deciduous teeth is

Table 2  
Chi-Squares for Signs Associated with the Eruption of the First Deciduous Tooth

Sign	Three Months Prior to Eruption of First Tooth	Two Months Prior to Eruption of First Tooth	One Month Prior to Eruption of First Tooth
Head Rolling	.16	.16	1.00
Poor Appetite	7.60 <sup>1</sup>	3.81	.91
Drooling	4.54 <sup>2</sup>	1.60	.03
Biting Lip	35.52 <sup>1</sup>	13.47 <sup>1</sup>	1.69
Biting Objects	22.58 <sup>1</sup>	8.76 <sup>1</sup>	2.34
Biting Hand	21.34 <sup>1</sup>	7.61 <sup>1</sup>	1.19
Vomiting	1.37	1.37	.58
Stuffy Nose	16.90 <sup>1</sup>	10.49 <sup>1</sup>	4.46 <sup>2</sup>
Night Crying	43.42 <sup>1</sup>	24.87 <sup>1</sup>	6.72 <sup>1</sup>
Restlessness	38.77 <sup>1</sup>	15.97 <sup>1</sup>	3.94 <sup>2</sup>
Convulsions	.00	.00	.00
Face Rash	7.74 <sup>1</sup>	4.44 <sup>2</sup>	.73
Diaper Rash	12.36 <sup>1</sup>	4.95 <sup>2</sup>	3.25
Loose Stools	21.33 <sup>1</sup>	13.42 <sup>1</sup>	3.56
Constipation	1.00	1.00	.00
Rectal Temperature over 100.0F (37.7C)	4.44 <sup>2</sup>	1.20	.49
Cough	28.79 <sup>1</sup>	13.14 <sup>1</sup>	2.77

<sup>1</sup>P<.01

<sup>2</sup>P<.05



**Table 3**  
**Disturbance Associated With Teething Observed In British and American Infants**

	<b>British N = 244</b>	<b>Kravitz N = 110</b>
	<i>(All Anterior Deciduous Teeth)</i>	<i>(1st Anterior Deciduous Tooth)</i>
Coughing	15.6%	46.3%
Face Rash	20.5%	15.4%
Loose Stools	8.0%	34.5%
Diaper Rash	6.7%	26.3%
Poor Appetite	49.5%	17.2%
Drooling	53.5%	90.9%
Irritability (Restlessness)	69.2%	79.1%
Fever 100.1-101F Rectally	8.9%	10.0%
Coryza	14.7%	43.6%
Vomiting	9.3%	4.5%
Night Crying	62.5%	68.1%
Constipation	9.8%	1.8%

also statistically significant. The cause is not known. The association of diaper rashes with teething could result from the loose stools. Slight elevations in the rectal temperature (100.1-100.8 F. 37.7-38.2 C.) were noted in 10% of the infants. The cause is not known but slight elevations in temperature in teething infants have been described by authors of pediatric and dental textbooks.<sup>4,12</sup> Many physicians have been reluctant to admit that teething causes signs because they fear that mothers will attribute to teething every respiratory and gastrointestinal infection associated with high fever. In our experience rectal temperatures over 101.0 F. (38.3C.) exclude the possibility of teething.

Lip biting as a sign of eruption of the deciduous incisors was previously reported by Kravitz<sup>19</sup> who noted its presence in 186 of 200 (93.0%) normal infants. The median age of onset was 5.3 months. Lip biting decreases after the eruption of the lateral deciduous incisors.<sup>20</sup> Lip biting as a sign of teething was also noted by Massler<sup>21</sup> who reported that children of six and seven years frequently exhibit this habit when they cut their permanent incisors.

The large number of infants (68.1%) who were observed to have night crying while cutting their first deciduous tooth is of significance to physicians as well as parents. Prolonged crying as a precipitating cause of the "battered baby syndrome" has been stressed by Brackbill<sup>22,23</sup> who has noted the inability of some parents to tolerate or cope with this type of behavior. Restlessness and night crying may continue for several weeks prior to and during the eruption of each tooth. For this reason it is important that physicians be more understanding toward the distraught mother or overworked father who calls his physician for help to relieve the nightly crying and restless-

ness of the teething infant. Doctors should carefully evaluate the disturbances associated with teething and give proper medications to relieve each infant's severe periods of crying and restlessness as they would do when treating an earache.

As Mindlin<sup>14</sup> has previously noted, teething is the second most frequent reason for bringing a sick white infant to a doctor's office or clinic, the other significant reasons being colds and gastrointestinal infections. Colds share many signs associated with teething. Both exhibit coughing, coryza, low grade fever, poor appetite, crying and restlessness. Doctors often have great difficulty in distinguishing between the conditions. Teething has a more gradual onset than a cold and may persist for weeks, while colds usually terminate in one week. Both gastroenteritis and teething show frequent loose stools, diaper rash, restlessness and crying. Teething usually results in two to four loose stools daily, a gradual onset and persistence of the loose stools for weeks and no significant weight loss, while gastroenteritis is more acute in onset and is associated with severe vomiting, five to twenty stools daily, marked weight loss and a shorter course.

Our study and the studies of Seward<sup>16</sup> and Tasanen<sup>17</sup> indicate that teething produces certain signs which disturb most infants and change their behavior. The disturbances accompanying teething should be viewed as a part of normal infant development. More studies are needed to determine the relation of temperament and pain threshold to the presence or absence of signs of teething. ◀

#### References

A complete list of references for "Teething in Infancy: A Part of Normal Development", may be obtained by writing the Illinois Medical Journal, 55 E. Monroe Street, Suite 3510, Chicago, 60603.

# *Acute and Chronic Management of Children With Sick Cell Anemia and Cerebrovascular Occlusive Crisis*

BY RUTH ANDREA SEELER, M.D., AND JOYCE E. ROYAL, M.D./CHICAGO

*There appears to be an approximate 4% to 10% incidence of cerebrovascular occlusions in children with sickle cell anemia.<sup>1-4</sup> These cerebrovascular occlusions can occur in children who are otherwise well, or may be associated with mild colds or other types of crises. They have occurred in children as young as 2-3 years and extend throughout the pediatric age range.<sup>1,5</sup> There does not appear to be any sex predilection.*

*We have reviewed our 9.5 year experience with this type of crisis at the Cook County Hospital in order to get an overview as to the outcome with modern management.*

## **Clinical Data**

Since July 1, 1967, there have been 12 children (4 males and 8 females) ages 3.3 years to 14 years of age who have had cerebrovascular occlusions. Two children had had bacterial meningitis 23 months and 5.5 years prior to the cerebrovascular crisis. Eight of the children were otherwise well and four were either suffering from symptoms of an upper respiratory tract infection, or had been in a mild pain crisis in the preceding 48 hours.

Three children died with their first cerebrovascular occlusive crisis, and one child subsequently died after several recurrences, giving an

overall mortality rate of 25%. These four deaths accounted for 15% (4/26) of the deaths that have occurred since January 1, 1967.

Four children had recurrences. One child died during a recurrence, and two children developed additional severe neurological sequela. One child was initially placed on chronic transfusion, but the parents stopped bringing the child because he had made a complete recovery. Three months later he had a second cerebrovascular occlusion and has a residual mild upper extremity weakness. He is now on a chronic transfusion program.

One child, not chronically transfused, has gone 8.5 years without subsequent cerebrovascular occlusion. This child was so severely neurologically handicapped by the initial episode that institutionalization was recommended.

Five patients are on chronic transfusion and are doing well. None of the eight survivors have a seizure disorder.

Autopsy was obtained in the four children who died. Diffuse cerebral atrophy was found in the one child who had died of inanition following several cerebrovascular accidents, which left her incontinent, aphasic, and with fixed flexion con-

---

RUTH ANDREA SEELER, M.D., is chairman of the division of pediatric hematology-oncology at Cook County Hospital and the Hektoen Institute for Medical Research in Chicago.

JOYCE E. ROYAL, M.D., is an attending associate in the division of pediatric hematology-oncology at Cook County Hospital and the Hektoen Institute for Medical Research in Chicago.

tractions of all extremities. Of the three children who died acutely in their first cerebrovascular occlusive crisis, one child showed a massive intracerebral and subarachnoid hemorrhage. The other two children showed diffuse edema and encephalomalacia involving the right cerebellar hemisphere and in the other child, the right frontal and both basal ganglion areas.

### Discussion

It used to be thought that sickle cells occluded the capillary bed only. Recent angiographic data revealed that the major cerebral vessels were occluded.<sup>1,3,4</sup> The current concept of pathogenesis is that the sickling occurs within the *vasa vasorum* of the major blood vessels. As with all sickling, this is followed by ischemic necrosis and heals with fibrosis and scarring. This could lead eventually to occlusion of a major blood vessel. The outcome of an acute cerebrovascular occlusion varies from complete recovery to death, with all intermediate degrees of neurological handicap. The recurrence rate of cerebrovascular occlusion in a child who has already had a cerebrovascular occlusion is much higher than the incidence in children with sickle cell anemia per se—although not known, it is estimated at 30% to 50%. A less common neurological problem is massive intracranial hemorrhage, which was present in one of our patients.<sup>6</sup>

The approach to these patients has changed over the nine year review. Initially, we converted the children to hemoglobin A after the cerebrovascular accident. The prevailing belief at the time was that the occlusion was in the cerebral capillaries and we were attempting to provide erythrocytes that would not sickle and thus optimize neurological recovery. It was thought that there was the edema and hyperemia at the edge of the infarcted area, which would lead to slow flow, the conditions optimal for further sickling. This could be prevented by the transfusion of normal erythrocytes.

The next step was the recognition that the recurrence rate is far higher in those children who have already had a cerebrovascular occlusion. Therefore, we began a chronic transfusion program for these children. Because there was no surgical procedure to offer these children, we have not routinely done cerebral angiograms. It has recently been shown that a one year transfusion program reverses the area of narrowing, but does not have a proven effect on the neurological sequela.<sup>4</sup> An unanswered question remains as to whether one year is enough or should

these children be transfused for life? One group is planning a five year transfusion program.<sup>1</sup>

Over the years, there has also been a change in the clinical picture of cerebrovascular occlusion with a marked decline in the reported incidence from 26%.<sup>5</sup> We believe it is important that 75% of our children were otherwise well at the time of cerebrovascular occlusion. This may reflect more aggressive management with intravenous fluids and antibiotics for intercurrent pain crisis and infections in children with sickle cell anemia.

We convert the child to hemoglobin A over several days. This is done by the transfusion of 20 cc/kg of packed erythrocytes. This usually results in an increase in the hematocrit of 20 points. The hematocrit on packed cells is approximately 80% and the blood volume is approximately 80 cc's per kg; therefore the number of cc's per kg infused is approximately equal to the increase in hematocrit points.

When the hematocrit exceeds 36 or the hemoglobin 12 gms per 100 ml, there is decreased erythropoietin production and, as a result decreased endogenous sickle cell production. The sickle erythrocytes have an approximate half life of 7 to 11 days and will be cleared rapidly from circulation. A second transfusion of hemoglobin A given 4 to 7 days later will result in the conversion of the child to essentially hemoglobin A. By giving transfusions at 4 to 5 week intervals, and keeping the hemoglobin over 10 gms% hematocrit over 30, it is possible to maintain the percentage of hemoglobin S under 25% without much difficulty. We find this procedure very satisfactory and have not used modified exchange transfusions.

Over the physiological range of hematocrit, there is very little change in viscosity with increasing the hematocrit. With a hematocrit over 65, the viscosity rises rapidly with further small increments in hematocrit. However, since we are working with hematocrits under 45, this is not a significant factor.

The use of washed packed erythrocytes has eliminated the transfusion reactions due to platelet and white cell antigens. One of our patients has developed antibodies to minor blood group factors which require additional screening of donors to find compatible units. The incidence of hepatitis using volunteer blood, all of which has been tested for the hepatitis antigen by RIA technique, and in addition is washed, has been zero.

Chronic transfusions seem justified for these children for the following reasons: first, there

is the high recurrence rate in the untransfused child who has had a cerebrovascular occlusive crisis. Secondly, studies with angiograms show better patency of the major cerebral vessels following one year of chronic transfusion.<sup>4</sup> Although no data demonstrate that chronic transfusion improves the neurological status, it will certainly prevent recurrences.

An unanswered question remains as to the pathogenesis of iron due to the transfusions. Children with chronic hemolytic anemias absorb pathological amounts of iron from gastrointestinal tract. It remains to be seen if there is an additional iron burden due to chronic transfusion, as the higher hemoglobin might lessen the iron absorption from the gastrointestinal tract.

Cerebral vessel angiograms are extremely dangerous in the untransfused child with sickle cell anemia, because the hypertonicity of the contrast media causes sickling. Cerebral vessel angiograms must not be done before converting the child to hemoglobin A.<sup>1,3</sup> Another procedure that should be avoided in these children is hyperventilation, as it decreases cerebral blood flow.<sup>2</sup> There is a report of a child who suffered a cerebrovascular occlusion during hyperventilation for EEG. The same paper also includes another child who suffered a cerebrovascular occlusion

while blowing up balloons.<sup>2</sup>

At present, there is no way to predict which child will have a cerebrovascular crisis. We have had no cases involving siblings, although we have numerous families with several children with sickle cell anemia. Until a non-toxic anti-sickling agent is found, we can only chronically transfuse those children who have sustained a cerebrovascular occlusive insult. ◀

#### References

1. Lusher, J. M., Haghighat, H., and Khalifa, A. S.: "A Prophylactic Transfusion Program for Children with Sickle Cell Anemia Complicated by CNS Infarction." *Am. J. Hemat.*, 1:265, 1976.
2. Allen, J. P., Imbus, C. E., Powars, D. R., and Haywood, L. J.: "Neurological Impairment Induced by Hyperventilation in Children With Sickle Cell Anemia." *Ped.*, 58:124, 1976.
3. Stockman, J. A., Nigro, M. A., Mishkin, M. M., and Oski, F. A.: "Occlusion of Large Cerebral Vessels in Sickle-Cell Anemia." *N.E.J.M.*, 287:846, 1972.
4. Russell, M. O., Goldberg, H. I., Reis, L., Friedman, S., Slater, R., Reivich, M., and Schwartz, E.: "Transfusion Therapy for Cerebrovascular Abnormalities in Sickle Cell Disease." *J. Ped.*, 88:382, 1976.
5. Portnoy, B. A., and Herion, J. C.: "Neurological Manifestations in Sickle Cell Disease." *Ann. Int. Med.*, 76: 643, 1972.
6. Falter, M. L., Sutton, A. L., and Robinson, M. G.: "Massive Intracranial Hemorrhage in Sickle-Cell Anemia." *Am. J. Dis. Child.* 125:415, 1973.

## MANUSCRIPT INFORMATION

Original articles will be considered for publication with the understanding that they are contributed only to the *Illinois Medical Journal*. The *Journal* assumes no responsibility for the opinions and claims expressed in the articles contributed.

Manuscripts should be typed, double spaced, and submitted in duplicate, one original and one carbon. An article should not exceed **12 to 16 manuscript pages**, (including illustrations) and should be briefer if possible. Please enclose personal glossy photos of author or authors. Snapshots are not suitable for reproduction.

References should be numbered in order of appearance in the text and conform to the following style in the order given: name of author, title of article, name of periodical with volume, page, month (day of month if weekly) and year. The *Journal* does not assume responsibility for the accuracy of

references used with articles.

The first page should list the title, the name of the author(s), degrees and any institutional or other credits as well as the author's mailing address. The title should be as short as possible. Pages should be numbered consecutively. Tables are to be typed, numbered and accompanied by a brief descriptive title. Make drawings and charts in black ink. If photographs are submitted, send black and white glossies. Number illustrations consecutively and indicate their place in the text. Number, indicate the top and place the author's name on the back of each illustration.

Address manuscripts to:

*Illinois Medical Journal*  
55 E. Monroe St., Suite 3510  
Chicago, Ill. 60603



# Physical Characteristics of Colon Polyps as a Determinant of Rational Management

LARRY C. GUNN, M.D., F.A.C.S./HINSDALE

*As more thorough routine medical examination is adopted, the management of asymptomatic adenomatous polyps of the colon becomes a more frequent consideration. The various types of colorectal polyps found are confusing to the surgeon, and management becomes difficult on occasion. Management of polyps must be guided by an awareness of specific pathologic findings. A recent patient studied by the author highlighted certain of these pathologic and therapeutic considerations.*

## Case Report

A 57-year-old white female was admitted to the hospital with right upper quadrant abdominal pain present for 8 months and associated with nausea, anorexia, fatigue, and equivocal weight loss. No other significant symptoms were present. Past history revealed a hysterectomy and bilateral salpingo-oophorectomy for benign disease and an incidental appendectomy 12 years prior to admission. Family history was positive for several malignancies. Physical examination revealed hepatomegaly with palpable hard non-tender nodules, but no other abnormalities. SMA/12, CBC, UGI, and chest X-ray were normal. Oral cholecystogram revealed cholelithiasis. Barium enema revealed a 1.5 cm sigmoid polyp. Liver scan was consistent with metastatic replacement disease. CEA was 18.9 ng/ml (normal 2.5). Percutaneous needle biopsy of the liver was non-diagnostic. Colonoscopy was performed and a single 2 x 1 x 0.5 cm mixed adenomatous and villous pedunculated polyp was excised. Microscopic evaluation revealed one small area of superficial focal adenocarcinoma. Specifically, no infiltration of the supporting stalk was found.

A laparotomy was performed to confirm the liver metastases. No lesions of the gastrointestinal

tract or regional nodes were found. The uterus, both ovaries, and appendix were surgically absent. The gallbladder contained one large stone, but was otherwise normal. No cholecystectomy was performed. Several hard umbilicated hepatic lesions were encountered. Two were biopsied and found to harbor metastatic adenocarcinoma.

## Discussion

A recent study by Shatney,<sup>1</sup> *et al.*, established the incidence of clinically detectable adenomatous polyps as 4.5% in females and 9% in males older than 30 years, with a 2-4% incidence of carcinoma formation within the polyp. The percent of malignancy reported by others ranges from 6.8% to 19.5%.<sup>3</sup> (Polyp size is an important consideration: the chance of malignancy in a polyp less than 1 cm in diameter is 1 in 30).<sup>3</sup> Thus a sizable patient population exists for whom a significant therapeutic decision must be reached: endoscopic excision or colon resection.

Sessile polyps will not be considered since there is general agreement that sessile polyps harboring carcinomatous changes should be resected. Although still controversial, many investigators feel there is some relationship between adenomatous polyps of the colon and carcinoma arising in this organ. In the past this controversy, excellently summarized by Buntain, *et al.*, had practical implications: the risk of laparotomy when excising those polyps above the reach of the sigmoidoscope had to be considered. Now that colonoscopy with its low incidence of complication is readily available, it is the procedure of choice for excising pedunculated polyps, thus obviating laparotomy for 96-98% of patients harboring polyps. **Again, there is a fairly uni-**



LARRY C. GUNN, M.D., F.A.C.S., is a clinical assistant professor of surgery at the Abraham Lincoln School of Medicine at the University of Illinois Medical Center in Chicago. Dr. Gunn is a member of the ISMS Committee on Manpower and Advisory Committee to Physicians in Training, as well as an examiner for the American Board of Surgery.

form agreement that a segmental bowel resection should be performed on most patients in whom the excised polyp is found to harbor invasive carcinoma.

However, the management of the remaining few patients is open to debate. Endoscopic resection of pedunculated polyps with *in situ* carcinoma not involving the neck or stalk is now widely accepted as adequate therapy.<sup>1-3</sup> This philosophy is based on the common assumption that metastases from carcinoma *in situ* arising in a pedunculated adenomatous polyp do not occur.<sup>1</sup> Although this is probably true, not all pedunculated lesions containing carcinoma without stalk invasion can be considered innocuous. Pedunculated lesions with villous characteristics, size > 1 cm,<sup>4</sup> as well as lesions that invade the submucosa, present more ominous findings. In addition to the case study just presented, Manheimer<sup>5</sup> has reported on such a pedunculated villous tumor which metastasized to the liver.

Therefore, the practice of accepting colonoscopic polypectomy as adequate therapy for all pedunculated polyps harboring *in situ* carcinoma must be challenged. Metastases can occur from *in situ* lesions especially if the polyp contains villous components. Since the patients reported herein and by Manheimer had hepatic metastases, no curative procedure was available. **However,**

the existence of these hepatic metastases raises the strong possibility that other similar lesions are being inadequately treated by polypectomy when, instead, standard segmental resection is what is necessary for cure.

In addition to morphologic and size criteria, the CEA assay may be of benefit in selecting patients for surgery, reserving operative procedures for those patients with an elevated assay alone, or an elevated assay which fails to fall after polypectomy. In any event, as our ability to treat potentially pre-malignant disease of the colon improves with increased use of the colonoscope, we should not jeopardize the chance of cure in early lesions by relying exclusively on local therapy for all polypoid lesions. ◀

#### References

1. Shatney, C. H., Lober, P. H., Gilbertsen, V. A., and Sosin, H.: "The Treatment of Pedunculated Adenomatous Colorectal Polyps with Focal Cancer," *Surg. Gynec. & Obstet.* 139:845, 1974.
2. Wolff, W. and Shinya, H.: "A New Approach to Colonic Polyps," *Ann. Surg.* 178:367, 1973.
3. Silverberg, S. G.: "Focally Malignant Adenomatous Polyps of the Colon and Rectum," *Surg. Gynec. & Obstet.* 130:103, 1970.
4. Buntain, W. L., Re Mine, W. H., and Farrow, G. M.: "Premalignancy of Polyps of the Colon," *Surg. Gynec. & Obstet.* 134:499, 1972.
5. Manheimer, L. H.: "Metastasis to the Liver from a Colonic Polyp," *New Engl. J. Med.* 272:144, 1965.

---

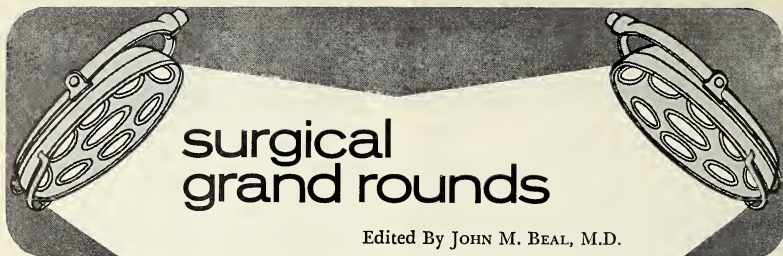
## EKG

(Continued from page 242)

**Answers: 1. A,B,C 2. A,B,C**

The ECG shows sinus rhythm with large Q waves from lead V<sub>1</sub> to V<sub>4</sub> confirming a diagnosis of anteroapical myocardial infarction. The QRS duration is prolonged to 0.12 sec. with a large R wave in leads V<sub>1</sub> to V<sub>3</sub> and a large S wave in leads I, V<sub>5</sub> and V<sub>6</sub>. This is complete right bundle branch block. The QRS axis is approximately -80° for a diagnosis of abnormal left axis deviation. This is bifascicular or bilateral bundle branch block and speaks for severe coronary artery disease. Although there was some improvement in his heart failure, coronary care unit monitoring demonstrated long runs of ventricular tachycardia (VT) not shown here. His condition would deteriorate during VT and multiple D.C. cardioversions were required in addition to

antiarrhythmic therapy. Serum enzymes and serial ECG's did not confirm a new myocardial infarction. No evidence of progressive atrioventricular block was seen, and shock was not a problem. The patient's condition was marginal in sinus rhythm but would deteriorate markedly during VT. This arrhythmia could not be controlled with drugs. Therefore, cardiac catheterization and coronary angiography were recommended. The left ventricular angiogram demonstrated a large anterior aneurysm. The left anterior descending artery was totally occluded and never visualized. The left circumflex artery was dominant and had a 90% proximal stenosis. The right coronary artery was small and normal. Cardiovascular surgery was recommended. For further reading see "Surgical Treatment of Refractory Life Threatening Ventricular Tachycardia" *American Journal of Cardiology* 32:909-912, 1973.



*Surgical Grand Rounds are held weekly on Tuesday at 5:00 p.m. in the Offield Auditorium of the Passavant Pavilion of Northwestern Memorial Hospital. Patient presentations from Northwestern Memorial Hospital and the Veterans Administration Lakeside Hospital form the basis of the discussions. This case report was part of the Surgical Grand Rounds of February 17, 1976.*

## Case Report: Giant Diverticulum of Sigmoid

**Dr. Joseph Russ:** A 74-year-old man complained of anal pain. He had a history of right lower quadrant and lower abdominal pain of three months duration that was relieved by defecation. One month before admission he noticed intermittent rectal bleeding. His past history included a ventriculoperitoneal shunt, following a subarachnoid hemorrhage and secondary hydrocephalus. Physical examination revealed few findings. His abdomen was soft and without masses or tenderness. Tenderness on rectal examination was detected anteriorly. Proctoscopic examination, however, was normal and did not demonstrate an anal fissure. Laboratory findings were within normal limits.

**Dr. Emanuel Calenoff:** Plain films of the abdomen were obtained and demonstrated a large, gas-filled area adjacent to the sigmoid colon, which measured approximately eight centimeters in diameter. Barium enema examination was performed and this air-containing cavity filled with barium, thus demonstrating a communication with the colon. (Fig. 1)

**Dr. Joseph Russ:** Because a fistulous communication was demonstrated between the pericolic gas filled structure and the colon, surgery was indicated. A sigmoid resection was performed.

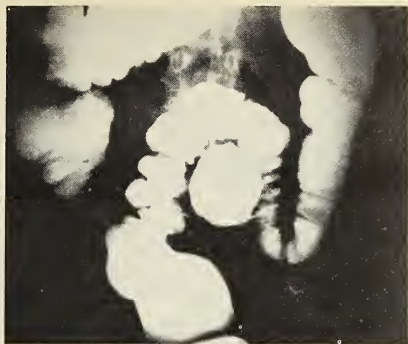
### Surgical Examination

**Dr. Hector Battifora:** On opening the segment of colon, multiple openings of diverticular pockets were seen. In addition, there was a large opening communicating with a cystic structure. Further inspection revealed another fistulous communication. Microscopic examination demonstrated the cavity to be lined with inflammatory tissue, with both acute and chronic changes present. This had the appearance of a large chronic abscess.

**Dr. Joseph Russ:** Diverticulitis of the colon may be associated with a variety of complications. The most common are perforation, fistula formation, abscess, and hemorrhage. One of the unusual complications is the development of a large, gas-filled cyst, which may be seen on the plain abdominal film and which may or may not be filled at the time of barium enema. The differential diagnosis includes 1) giant diverticulum of the colon, 2) giant air cyst, and 3) intramural abscess.

There has been controversy concerning the differentiation between giant diverticulum and giant diverticulum and giant air cysts. Strictly speaking, a giant diverticulum should contain layers of bowel in the cyst wall, whereas, the wall





**Figure 1**

Barium enema demonstrated a large cavity, filled with barium, which communicated with the sigmoid colon.

of a giant air cyst is composed of only fibrous and granulation tissue, as demonstrated by this patient. The histologic study of the cyst in our patient revealed fibrosis and granulation tissue with acute inflammation of the inner portion of the cyst.

Intraenteric abscesses usually have an acute presentation. The patient is usually acutely ill, with evidence of peritoneal irritation, abdominal tenderness, fever, and leukocytosis. The differential diagnosis includes other causes of intra-abdominal abscess, such as perforated appendicitis.

### Clinical Similarities

Giant diverticulum and giant air cyst have similar clinical characteristics. The differential diagnosis includes causes of other intra-abdominal gas-filled structures. Emphysematous cystitis may be caused by the presence of gas-forming bacteria within the bladder. These patients have pneumaturia and an IVP will demonstrate an air-filled bladder. Pneumatosis cystica intestinalis should not present a problem in diagnosis, because numerous internal air filled cysts are present along the intestinal wall, but do not attain the size of a giant air cyst. They involve the jejunum more commonly than the colon and 85% are associated with other intra-abdominal pathology. The possibility of carcinoma may be considered in some because of deformity produced by the cyst and the associated inflammation. Congenital duplication of the colon occurs characteristically in a different age group.

### Historical Data

Giant air cysts of the sigmoid colon are a very uncommon complication of diverticulitis. Only approximately 30 cases have been recorded since the first report in 1946. It is more common in men. Of the 30 cases, 17 have been men and 13 women, with an age range of 38 to 79 years. Twenty-six patients had pain, most commonly abdominal pain in either left or right lower quadrant. Some have presented with rupture of the cyst and generalized peritonitis. Duration of symptoms has varied from a few days to several years. The pain occasionally increases with straining on bowel movement. In 22 of the cases reported, a palpable mass was present and in some was asymptomatic. Five patients had rectal bleeding, and 13 in whom barium enemas were performed, the cyst was filled. The size has varied from 6 to 27 centimeters.

When removed, the cysts have been found to contain a variety of substances, including air, pus, stool, blood, and barium.

The pathogenesis of giant diverticula or cysts was described in 1946 and has not been seriously challenged. There appears to be a subserosal perforation secondary to diverticulitis, followed by a loculation of air and a ball-valve effect. Enlargement of the cyst frequently occurs during straining, which may account for exacerbation of pain during defecation.

### Conclusion

The preferred treatment is a one-stage resection, as performed in this patient, with end-to-end anastomosis. Diverting colostomy is seldom necessary.

**Dr. Gabriel Lorenzo:** Whether there is a real difference between giant diverticula and giant air cysts is hard to say. This may be an academic point because the clinical presentation is similar. Both are complications of diverticulitis and, therefore, the most effective treatment is resection of the involved colon. This patient had a very benign postoperative course. Resection not only removes the cyst, but also prevents the potentially life-threatening hazard of perforation and consequent peritonitis. This is an uncommon lesion but is one that can be detected readily. The presence of an air-filled space in the pelvis should alert one to the possibility of such a lesion. Most of these patients do not have the classical picture of sigmoid diverticulitis, although they occur in the same age group. ◀



# Simultaneous Open Heart Surgery In Combination With Other Surgical Procedures

BY JOSEPH C. CLEVELAND, M.D., F.A.C.S., F.C.C.P./URBANA

*Five cases of patients undergoing a primary cardiac surgical procedure who had a second or third operative procedure done simultaneously are presented. The safety of such planned complex surgical operations involving the heart and other organs is demonstrated, and the need for individualization of surgical therapy and surgical judgment is stressed.*

For many years, surgical teaching and practice held to the principle that only one major operation was done in a single setting. This was because the risk factor increased markedly as the length of surgery and additional procedures were added. Improvements in pre- and post-operative care plus the safety of appropriately administered anesthetics have allowed combinations of general surgical procedures to be planned and executed safely.<sup>1</sup>

Consideration can now be given to combining simultaneously corrective cardiac surgery with other needed surgical procedures. Hazards of bleeding or hemodynamic instability were previously the main contraindications to combination procedures. As the state of the art has progressed, the increased safety of cardiac surgery has allowed needed combinations of other sur-

gical procedures to be safely added to the heart operation.

Five cases which exemplify the position that combination surgery can be done safely are presented.

## Case Material

All surgical cases requiring pump oxygenator support operated in the year August 1, 1975, to August 1, 1976, were reviewed. Five of 81 total cases had combination surgery and are presented.

**Case #1**—A 67-year-old male had experienced progressive fatigue, exertional dyspnea and listlessness. Admission to the hospital was prompted by a syncopal episode. A harsh systolic murmur originating from the aortic area was identified. Cardiac catheterization revealed severe calcific aortic stenosis. The patient also had coronary arteriography. This revealed a 75-80% stenosis of the proximal left anterior descending artery.

Operation was performed May 26, 1976. The severely calcified aortic valve was excised and replaced with a #23 Carpentier-Edwards valve (porcine xenograft). In addition, a saphenous vein coronary artery bypass graft was constructed to bypass the LAD stenosis. The patient recovered from surgery without incident and was discharged on the 19th post-operative day. Early follow-up reveals a continuing satisfactory course.

**Comment:** Although this patient did not have



JOSEPH C. CLEVELAND, M.D., F.A.C.S., F.C.C.P., is a cardiac surgeon at Carle Clinic in Urbana and a member of the cardiovascular and thoracic surgery section of that clinic. Dr. Cleveland is widely published and a fellow at both the American College of Surgeons and American College of Chest Physicians.

angina, the critical stenosis of his LAD coronary artery was considered a significant risk factor in his short and long term result. Thus, in addition to correction of his aortic stenosis, which seemed to be the main cause of his symptoms, concomitant aorto-coronary bypass graft surgery was done. Although Dr. John Kirklin notes that the state of our present knowledge does not permit a definitive statement regarding the question of whether to bypass coronary artery lesions when performing aortic valve replacement, cardiac surgeons at the Mayo Clinic and the University of Oregon have found this combination of surgical procedures very gratifying.<sup>2-4</sup>

**Case #2—**A 56-year-old male was seen for routine follow up two years after an aortofemoral graft for LeRiche syndrome. This surgical result was quite satisfactory, but a new complaint was exertional angina pectoris. An exercise electrocardiogram was strongly positive, very early, with hypotension and marked ST segment depression. He was admitted to the hospital for cinecoronary angiography. A left carotid bruit was also obvious at the time. Coronary arteriography revealed a 75% stenotic lesion of the left main coronary artery. Arch aortography revealed an 85% obstructive lesion at the left carotid bifurcation.

Operation was performed on January 6, 1976. A left carotid endarterectomy was done followed by double coronary artery bypass grafting to the left anterior descending and obtuse marginal branches of the left coronary tree. Recovery was uneventful and he was discharged on the 12th postoperative day.

**Case #3—**A 55-year-old male was severely incapacitated with angina pectoris and transient ischemic attacks involving both cerebral hemispheres. A high pitched bruit was present over the left carotid and a lower pitched bruit was present over the right carotid. Study of the coronary arterial tree showed complete occlusion of the right coronary artery with 95% proximal stenosis of the left anterior descending, diagonal and two posterolateral branches of the circumflex. Arch aortogram showed a 95% occlusion of the left carotid bifurcation and 85% stenosis of the right carotid bifurcation. The patient was right handed.

He was operated on November 18, 1975. A left carotid endarterectomy preceded cardiopulmonary bypass wherein grafts were constructed to the right coronary artery (after endarterectomy),

the two posterolateral branches of the circumflex artery, the left anterior descending and diagonal branches of the coronary tree. The patient made an uneventful recovery from surgery and was discharged on the 14th postoperative day. He was free of angina and left cerebral hemisphere transient ischemic attacks thereafter, but continued to have symptoms of right cerebral insufficiency. Accordingly a right carotid endarterectomy was done January 14, 1976. Recovery was uncomplicated and he has resumed full employment.

**Comment:** Carotid endarterectomy done immediately before coronary artery bypass surgery seems a logical approach to the problem of combined carotid and coronary disease. If done separately, the risk of stroke is increased when the coronaries are done first; likewise the risk of myocardial infarction is increased if the carotid procedure is done first (in separate procedures). In 27 patients managed in all three sequences at the University of Oregon, the simultaneous approach proved to be the safest.<sup>5</sup>

**Case #4—**A 49-year-old female had suffered severe rheumatic fever in her youth. She was known to have rheumatic heart disease for years with mitral and aortic valve involvement. Because of increased fatigue, dyspnea, and orthopnea, cardiac catheterization was performed showing significant mitral stenosis with 3+ regurgitation. She also had mild aortic stenosis with minimal insufficiency. Recommendation was made for mitral valve replacement.

Another health problem had been repeated attacks of cholecystitis. The gallbladder was known to contain stones.

Operation was performed on November 13, 1975. The mitral valve was excised and replaced with a #23 Bjork-Shiley prosthetic valve. A cholecystectomy was done after separation of the patient from cardiopulmonary bypass and restoration of normal coagulation. The gallbladder was badly diseased. The patient was discharged from the hospital on the 13th postoperative day and has done well.

**Comment:** Surgery for mitral valve disease went very well allowing a needed cholecystectomy to be done. Total operating time was three hours.

**Case #5—**A 71-year-old male with maturity onset diabetes mellitus developed severe, disabling angina pectoris. Transient ischemic attacks involving the right cerebral hemisphere were

also complaints. He was known to have a single large gallstone. Cardiac catheterization was done, showing severe three vessel coronary artery disease. Arch aortography revealed a stenotic ulcerated plaque at the right carotid bifurcation. A date for surgery was set for three weeks after his studies. However, an attack of chest pain lasting 45 minutes brought him back to the hospital where he was observed in the CCU. This episode was felt to represent pre-infarctional angina and he was kept in the hospital for close control until the first open day for surgery. After several days, he developed typical acute cholecystitis with fever, leucocytosis, right upper quadrant abdominal tenderness, and scapular discomfort. This subsided on conservative management. A week later he underwent combined surgical procedures of (1) right carotid endarterectomy, (2) triple coronary bypass grafting, (3) cholecystectomy. Recovery was uneventful and he was discharged on his 18th postoperative day.

**Comment:** The recent attack of cholecystitis influenced the decision to add cholecystectomy to carotid and coronary surgery.

### Discussion

The decision of how much surgery to do on a patient who needs several procedures obviously must be individualized. There can be few rigid criteria in this regard to guide the surgeon. This is an area which gets back to what is called "surgical judgment." Obviously, the most pressing surgical problem should be addressed and then a judgment made about proceeding further.

In the field of cardiac surgery, this type of complex case has received consideration for combined surgical attack on separate lesions only in recent years, primarily because heart surgery is becoming safer.

It is apparent that many patients with coronary artery disease will have some form of peripheral vascular disease in addition. My opinion is that carotid surgery should be done simultaneous to coronary bypass procedures. Elective revascularization of the lower extremities should be done later, however, as should most other procedures.

In the case of valvular heart disease, most cardiologists do coronary arteriography in patients over age 40 whether or not angina is a complaint. As Dr. Kirklin has noted, controlled studies do not yet exist to show whether bypass grafting done concomitantly with valvular replacement is desirous. However, most cardiac surgeons with sizable experience can anecdotally relate patients who should have done well after valvular replace-

ment but either died or had great difficulty because of myocardial infarction possibly related to tight stenosis of coronary arteries not bypassed. Thus the tendency is to bypass significant lesions, particularly in large vessels like the left anterior descending coronary artery. My opinion follows that trend.

The addition of general surgical procedures to cardiac surgery should not be done routinely, but only if they can be done expeditiously, and the need is rather pressing. However, as our experience attests, this can be done safely in selected cases. ◀

### Addendum

Seventy more consecutive cases requiring pump oxygenator support have been done since preparation of this report. Two combination procedures were done. One was combined left anterior descending coronary artery bypass with mitral valve replacement in a 55-year-old female with recurrent episodes of pulmonary edema related to critical mitral stenosis. A significant LAD artery stenosis was bypassed even though the patient did not have angina. The other case was that of a 57-year-old female with maturity onset diabetes, coronary artery disease with disabling angina, and symptomatic cholelithiasis. A 4-vessel aortocoronary bypass graft procedure was combined with cholecystectomy. Both patients recovered promptly without complications and have done well.

### References

1. Hohf, R. P.: "Combined Surgical Procedures." *Surgical Clinics of N. A.* 50:13, 1970.
2. Kirklin, J. W.: "Editorial Comment." *Yearbook of Cardiovascular Medicine*, p. 389, 1975.
3. Merin, G., Danielson, G. K., Wallace, R. B., Rutherford, B. D., and Pluth, J. R.: "Combined One-Stage Coronary Artery and Valvular Surgery." *Circulation* (Suppl. 3) 47 and 48, 173, 1973.
4. Anderson, R. P., Bonchek, L. I., Wood, J. A., Chapman, R. P., and Starr, A.: "Safety of Combined Aortic Valve Replacement and Coronary Bypass Grafting." *Ann. Thor. Surg.* 15:249, 1973.
5. Okies, J. E., MacManus, Q., Starr, A.: "Myocardial Revascularization and Carotid Endarterectomy—A Combined Approach." *Chest* 68:422, 1975.

# Doctor's News

**CHILD ABUSE** will be the subject of a conference sponsored by a coalition of state, private and national organizations, to be held May 1-3 in Springfield. The conference is designed to facilitate community resource networks for abused and neglected children. Discussion will revolve around cooperation between social service organizations, hospitals, police, schools, day care centers and homes, the judicial system, government and concerned citizens.

Over 7,700 instances of suspected abuse and neglect will be reported in Illinois this year. That figure represents 1,000 more cases than were reported last year—and 16 times the number in 1965, when the Illinois child abuse law was enacted.

The registration fee (\$25 before April 15 and \$30 thereafter) entitles participants to attend all meetings and workshops, in addition to a luncheon and dinner session. Further information may be obtained by writing Program Support Services, Illinois Department of Children and Family Services, 623 E. Adams Street, Springfield, 62706.

**BRAIN PACEMAKERS FOR CEREBRAL PALSY**—A research grant from the United Cerebral Palsy Research and Education Foundation will enable Richard D. Penn, M.D., of Rush-Presbyterian-St. Luke's Medical Center in Chicago, to investigate the function and future of cerebellar electrode implants for victims of cerebral palsy. Dr. Penn will develop guidelines for patient selection, because the benefits appear to differ among patients. In some instances, varying degrees of relief from speech impediments, muscle spasms and involuntary movements caused by brain damage have resulted from the four-year-old procedure. In addition, the researchers hope to determine the optimum time period for brain stimulation to continue after the implants have been made, and the possibility that relatively permanent transformations in the nervous system may accrue in some cases.

**PROJECT USA**—The AMA physician recruitment program for short-term service in rural areas has a special need for family practitioners at Indian Health Service and National Health Service Corps locations. The Indian Health Service sites range from Nevada to Montana and South Dakota during the months of April and May. National Health Service vacancies in Vermont, Pennsylvania and Wisconsin will be open at different times during April, June and July.

Project USA physicians are granted a \$400 per week stipend and round trip air fare for their efforts. Housing is available at all locations, and malpractice insurance is provided at Indian Health Service sites (although National Health Service Corps volunteers must have their own insurance).

Interested physicians are encouraged to contact John Naughton, AMA, 535 N. Dearborn, Chicago, 60610; (312) 751-6395.

**OFFICE MANAGEMENT SEMINAR SCHEDULED**—A four-day forum in personnel, financial and patient flow management will be offered in Chicago June 27-30. The meeting will focus on a wide range of office problems, and is designed to facilitate economized use of the physician's working environment. The seminar, which will be held at the Drake Oakbrook Hotel in Oak Brook, Illinois, is composed of three courses. Personnel Management, a two-day session, has a tuition fee of \$180, Patient Flow Technique, \$95 and Financial Management, \$95. Tuition includes luncheons and workbooks.

Further information may be obtained by contacting Conomikes Associates, Inc., 4270 Promenade Way, Marina del Rey, California 90291, (203) 823-4661.



**PHYSICIANS IN THE NEWS**—The Columbus-Cuneo-Cabrini Medical Center in Chicago has announced that **Erl Dordal, M.D.**, Chicago, will replace **Henry Russe, M.D.**, Chicago, as vice president of internal medicine. Dr. Russe, who has headed the department for nine years, will become vice president of the University of Chicago Medical Center and also deputy dean of clinical affairs, chief of staff at the hospitals and clinics and professor of medicine. Dr. Dordal is the former chief of medical services and head of gastroenterological care at Lakeside Veterans Administration Hospital, and is also chief of gastroenterology and associate professor in medicine at Northwestern University.

**Anthony R. Sapienza, M.D.**, Burr Ridge, vice president for medical affairs at Saint Mary of Nazareth Hospital Center, has been admitted as an honorary member of the Logan-Brophy Memorial Society. The Society is a Loyola University Medical Center affiliate which works to promote the needs and interests of oral surgery.

The Nominating Committee for the American College of Radiology has selected **Fredric D. Lake, M.D.**, Evanston, as its candidate for president of the College. Dr. Lake, director of the department of radiology at Columbus Hospital in Chicago, is a former president of ISMS, and the founding president of the Illinois chapter of the ACR. He has served as chairman of the ACR Board of Chancellors as well as chairman of the ISMS Task Force on Professional Liability for the past year. **John D. Stroud, M.D.**, Chicago, has been named associate dean for graduate and continuing medical education at the Abraham Lincoln School of Medicine. Dr. Stroud has functioned as assistant dean in charge of planning and program coordination since 1975.

At Northwestern University Medical Center—**I. Richard Goldstein, M.D.**, Chicago, an assistant professor at the medical school, has been appointed president of the medical staff . . . **Howard J. Sweeney, M.D.**, Evanston, has been named to head the division of orthopaedic surgery. Dr. Sweeney is currently on the staff as an assistant professor of orthopaedic surgery . . . **Peter Shrock, M.D.**, Evanston, an associate professor of clinical surgery, will serve as chief of the new section of pediatric surgery . . . **Toshio Narahashi, M.D.**, will serve as chairman of the department of pharmacology and professor of pharmacology. Dr. Narahashi is the former chief of the cellular neuropharmacology and toxicology laboratory at Duke University Medical Center.

**DIAMOND JUBILEE**—The American Urological Association will celebrate the 75th anniversary of its founding with an educational conference in Chicago, April 24th through 28th, 1977. The Association has announced that a wide variety of papers dealing with new techniques and ideas in urology will be presented at the meeting. Outstanding members of the field will present ten formal postgraduate courses in urology. In addition, annual awards for contributions to the science and the clinical practice of urology will be presented.

**TREATMENT FOR BURN PATIENTS**—A recent session of the University of Chicago monthly program for practicing physicians, "Frontiers of Medicine," hosted two physicians who have pioneered in research of the utilization of membranes from post-partum amniotic sacs as temporary dressing for serious burns. **Martin C. Robson, M.D.**, of the University of Chicago, and **Thomas J. Krizek**, Yale, have found that amniotic membrane dressings conserve protein and fluid and reduce pain in burn victims. It has also been found superior to the traditional pigskin dressings in permitting the development of blood vessels in deep burns.

## What Do We Want?



In 1976, the federal health budget was approximately \$135 billion; of this figure \$39.5 billion was spent on medical treatment of alcohol-tobacco induced problems and \$10.5 billion for medical treatment of drug abuse problems. At least \$2.5 billion was lost from fraud and misuse and abuse of federally-funded programs. How much was wasted on administrative costs is not known.

Some people in health care planning suggest that care would be improved and costs would be reduced if the government were to conscript doctors, put them on salary, and deploy them in the way that police, firemen and military personnel are assigned. Such a plan, however, would achieve neither goal.

The arithmetic is simple. Take the average physician's income of \$40 to \$50 thousand per year (the figure is generous), and multiply by the number of doctors in practice. If the total is subtracted from the government's \$135 billion bill, we are still left with more than 90% of the original figure. Even if doctors received no payment whatsoever for their services, hardly a dent would be made in the government's cost.

Altering our health care delivery system, then, comes no closer to solving fiscal problems than it does to solving health problems. There are no simple solutions. Two answers must evolve through philosophic changes in society and government. Changes which begin with the recognition that the misuse of alcohol, tobacco and drugs are medical problems. But they are medical problems for which governmental input is acceptable, because they are partially social in origin. The remainder of our nation's medical problems can best be solved by those who diagnose and treat sick people and who try to keep healthy people well.

Quality of medical care cannot be compromised merely to reduce costs. Nothing, really, is more costly than poor medical care.

*Joseph H. Skom, M.D.*

Joseph H. Skom, M.D.

# Abstracts of Board Actions

(Continued from page 238)

- B. Drs. J. D. Winterhalter, Rockford, and Max Klinghoffer, appointed as ISMS representatives to the Rape Law Advisory Committee.
- C. Dr. Tassos Nastos, Chicago, appointed chairman, ISMS Governmental Affairs Council, replacing Dr. Elliott Partridge.
- D. Dr. Ronald N. Pawl, Skokie, nominated for appointment to the Drivers License Review Board.
- E. Dr. William Lees, Lincolnwood, nominated for re-appointment to the Illinois Cancer Council Board of Trustees.

## Dr. Quentin Young

ISMS received from the Chicago Medical Society a letter commenting on Dr. Quentin Young's litigation with the Cook County Health and Hospitals Governing Commission. In the letter CMS: (1) Reiterated its support of due process for physicians; (2) Encouraged continued attempts to clarify the tenure position of salaried physicians in public hospitals, especially Cook County Hospital, and (3) Recommended that the AMA Board of Trustees appropriate up to \$15,000 to assist Dr. Young in his defense. ISMS has forwarded the letter to AMA without comment.

## ISMS-IFMC Liaison Committee

The Board urged IFMC to work directly with local county medical societies not now involved with any medical review organization in the development of any contracts for reviewing services under non-governmental programs.

## Fee Adjudication

The Board ratified the Executive Committee's recommendation to county medical societies regarding fee adjudication. County Societies were urged to:

—Continue fee adjudication until such time, if ever, as an investigation is commenced. At that time, rather than contesting the allegation of illegality, ISMS can decide to offer to discontinue the activity immediately. Legal counsel reports "There is a reasonable chance that the government would accept your agreement and the fact of discontinuance as sufficient to serve its enforcement purpose." To further reduce the risk, legal counsel suggests county societies consider eliminating the specification of a maximum fee by a peer committee that does not approve the fee charged by the physicians. In other words, instead of advising that the fee should be limited to a given amount, the peer review committee could simply conclude that the fee charged is higher than usual, customary and reasonable, leaving it to the parties to negotiate a lower fee if they can."

## Amendment to SSA Rules & Regs

ISMS has filed a formal objection to HEW's proposal to amend the rules and regulations governing disclosure of the names of providers accused of overutilization. HEW plans to require consultation with "an appropriate program review team appointed by the Secretary . . . or with a Professional Standards Review Organization where it has been authorized to assume the responsibilities of a program review team, as an alternative to prior consultation with a professional medical association." Current rules provide for consultation with medical associations before the names of accused providers are published.

## Medical Discipline

The Board adopted the following steps for initiating medical society disciplinary action and reporting to the Medical Disciplinary Board:

1. Request the Directors of the Department of Registration and Education and the Department of Public Aid to notify ISMS officially of all disciplinary actions taken against physicians.
2. Request hospital medical staffs to forward to county medical societies a report on disciplinary actions taken against staff members who are suspected of violating the Medical Practice Act.

This is not to be construed, in any way, as restricting the hospital from reporting the incident to the Medical Disciplinary Board. Such reporting should be encouraged.

3. Urge county medical societies to investigate the qualifications for continued membership of any physician who has been: (A) Disciplined by the Department of Registration and Education; (B) Suspended or terminated from the Medicare or Medicaid program; (C) Suspended from a hospital staff; or (D) Convicted of a felony.
4. Inform all physicians that suspected violations of the Medical Practice Act by their colleagues should be reported to their county medical society. All cases should be reviewed by a Society committee to determine their validity. If the review indicates reasonable grounds for further inquiry and no malice appears to be involved, the case should then be forwarded to the Medical Disciplinary Board without comment or embellishment.
5. Information relative to cases undergoing formal ethical proceedings by medical societies should not be forwarded to the Medical Disciplinary Board until those proceedings are concluded, including appeals.

This information will be forwarded to county medical societies and published in Action Report and the Illinois Medical Journal.

The Board also agreed to forward to the appropriate county medical societies the names of Illinois physicians disciplined by the Department of Registration and Education or terminated from the Medicaid program. The names will be accompanied by a request to investigate the qualifications for continued membership of these physicians.

Any case receiving an adverse decision will be: (1) Published in the Illinois Medical Journal to alert the membership; (2) Provided to the Illinois State Medical Insurance Service, Inc., for its records; (3) Updated monthly and maintained in the ISMS files for future reference; and (4) Submitted to AMA for its consideration in event the physicians involved apply for membership in another state.

### **Professional Liability Legislative Proposals**

Upon recommendation of the Task Force on Professional Liability, ISMS will seek to:

1. Amend Ch. 51, Sec. 73, of the Illinois Revised Statutes which allows patients to authorize an attorney or another physician to obtain copies of his medical records from his attending physician. The proposed amendment would exempt psychiatric records from this authorization and provide physicians with control over the conditions under which records would be copied.

2. Amend Ch. 110, Sec. 21.1 of the Civil Practice Act which authorizes the plaintiff to designate as respondents in discovery those individuals believed to have information essential to the determination of who should properly be named as additional defendants in the action. The proposed amendment would prevent attorneys from using this provision as a "fishing expedition" by: (A) Limiting the scope of discovery to the respondent's personal knowledge of the case involved; and (B) Requiring the plaintiff to pay the expenses and fees—as well as any lost earnings—incurred by the respondent in complying with the plaintiff's request.

3. Amend the new Arbitration Act to correct several deficiencies which would make its implementation dangerous.

4. Develop amendments to Ch. 91, Sec. 2B of the Medical Practice Act and Ch. 51, Sec. 101 of the Evidence and Depositions Act to broaden the definition of—and assure immunity for—peer review activities.

### **Proposed Definition of Peer Review**

The Board will present a resolution to the House of Delegates requesting adoption of the following definition of peer review:

Peer review is the evaluation by practicing physicians of the quality, appropriateness and efficiency of services ordered or performed by other practicing physicians. It is the all-inclusive term for medical review efforts including utilization review, quality of care, competence determination and ethical consideration.

Medical Society peer review shall be conducted whenever possible at the local level prior to being referred to a higher level by the county medical society.



The Committee on Committees was directed to redefine the functions of ethical relations committee separately from any consideration of peer review.

### **Third Party Intervention in the Practice of Medicine**

ISMS has requested the Health Insurance Association of America to submit proposed solutions to the problems of third party interference with the practice of medicine. In event they are not acceptable to the Illinois State Medical Society, the Board: (1) Directed legal counsel and staff to enter into negotiations with HIAA; and (2) Authorized referral of the problem to AMA for legal action.

### **Appeals From County Medical Societies**

The Committee on Constitution and Bylaws was directed to study the feasibility of limiting ISMS consideration of all appeals to procedural errors and new evidence. The committee also was requested to consider whether ISMS should continue to accept appeals involving fee adjudication.

### **Minimum Benefit Standard for Psychiatric Contract**

The ISMS Minimum Standards for Health Insurance Programs were modified so that usual, customary and reasonable fee concepts apply to physician-performed programs for psychiatric illness. The Board believes the revisions fulfill the intent of the House of Delegates' directive to place psychiatric benefits on an equal setting with other medical benefits.

### **Attending Physician Statements**

The Board endorsed the idea of insurance companies enclosing a pay voucher with their requests for attending physician statements. The physician would fill in his charges on the voucher—which would read "payable within 15 days"—and mail back to the company.

### **Medicare and Medicaid Brochures**

The Board approved a proposed 1977 version of "Medicare Misconceptions," which will be published and distributed with funds from the Council on Social and Medical Services and from outside sources.

The council's plans for producing a similar brochure describing Medicaid benefits has been postponed because of anticipated modifications in the Illinois Medicaid program.

### **Authorized Personnel in an Operating Room**

In the absence of controlled studies indicating patients are not placed in danger due to infection or other problems associated with non-authorized personnel present in an operating room, ISMS supports current state regulations defining who is authorized to be in the hospital operating and delivery rooms. Illinois Department of Public Health regulations currently state:

"No lay visitor shall be given access to the operating room during surgery. . . . The presence of the father of the baby in the delivery room shall be discretionary with the individual hospital. If the father of the baby is to be admitted to the delivery room of any hospital, the hospital shall first have adopted a policy statement on the matter which, among other things, establishes the following conditions:

(1) Written consent of both the mother and the attending physician; (2) Prior orientation preparation of the father of the baby and mother to this experience; and (3) Application of safeguards against the introduction of infection or other hazard by the father of the baby."

### **Surgical Procedures Requiring a Physician as First Assistant**

The Board adopted and will forward to the Illinois Department of Public Health the following suggested guidelines on surgical procedures requiring a physician as first assistant:

1. The patient's referring physician should be offered the opportunity to assist at any surgical procedure when qualified by training, experience and demonstrated competence through the usual medical staff channels. If the referring physician declines, the operating surgeon should have the prerogative to recommend whether a physician qualified by the Credentials Committee or a non-physician surgical assistant qualified by the Credentials Committee should assist in the procedure.
2. The State of Illinois should not attempt to set rigid, statewide guidelines due to the variations in local hospital circumstances throughout the state. However, broad guidelines may be developed which relate to criteria used by local medical staffs. These might include such factors as anesthesia risks, length of proposed procedure and technical requirements of the procedure.
3. The local medical staff, through its credentialing mechanism, should be allowed, and held responsible, to assure that a "qualified assistant", whether a physician or non-physician, assists in the operating room.

## **IDPA Yields on Key Medicaid Issues**

The Board was informed that ISMS has obtained several key concessions from IDPA regarding administration of Medicaid. Acting on House of Delegates' directives, the Society challenged IDPA's stance on corporate billing, confidentiality of office records, audit procedures and arbitrary reimbursement time limits. Following intense negotiations, IDPA agreed to:

1. Delay indefinitely implementation of the six-month time limit for submission of bills and notify physicians that the former 24-month limit is reinstated. After the cut-off-date, bills will be paid if re-submitted with proof that vouchers originally were presented within the required period. Physicians not reimbursed for past services may contact the IFMC Membership Services Division for assistance.
2. Accept during *fiscal audits* a price list or other evidence in lieu of private patient records. In *lab service audits*, equipment serial numbers will be accepted in place of office inspection . . . and IDPA will attempt to assign a physician-consultant to all *quality of care audits*.
3. Develop and promote in conjunction with ISMS an acceptable form that patients would sign authorizing a physician to release medical information to the Department.
4. Continue using code numbers on DPA Form 132 for commonly-performed procedures, but accept Current Procedural Terminology III coding for other procedures if proper explanation accompanies billing. IDPA also will update its Physicians Handbook to correspond to CPT IV.
5. Provide ISMS and the Medical Disciplinary Board with names of physicians terminated from Medicaid.

In a related development, the Board of Trustees approved a provider agreement form-incorporating allowances for group/corporate billing-for consideration by IDPA. Meanwhile, legal counsel is investigating IDPA's fiscal audit procedures to identify other possible areas of negotiation and determine which records IDPA legally may demand from physicians. A complete report will be presented to the House of Delegates in April.

## **Guidelines on Goal Statements for Health Systems Plans**

ISMS will urge the Illinois Department of Public Health and the State Health Coordinating Council to delete that portion of the "State Health Planning Needs and Priorities" dealing with the priority that families or individuals should not expend more than 12 percent of annual incomes for needed health care services.

## **Springfield Legislative Conference**

A Legislative Conference stressing education of physicians to legislative problems and legislators to medical issues will be held June 8, 1977, at the Forum 30 Hotel in Springfield.

## **Home Addresses**

To assist the Public Affairs Committee in its proposed physician voter registration and awareness project prior to the 1978 elections, the Board will request all ISMS council and committee members to provide the Society with their home addresses. It also urged IFMC, IOCME and ISMIE to seek home addresses of participating physicians on all forms, rosters and other documents.

## **Legal Consequences of Rebate Arrangements with Laboratories**

The Board will ask the House of Delegates to approve a resolution calling for an amendment to PA 79-1431, Laboratory Services Act, so that information regarding the name and address of the lab performing the tests would be available to patients upon request.

## **Use of Term "Physician"**

On advice of legal counsel and the Governmental Affairs Council, the Board will ask the House of Delegates to re-consider Resolution 76N-57, which would require ISMS to attempt to prohibit anyone other than a fully licensed physician from using the title, "Physician."

## **Generic Prescribing**

The House of Delegates will be asked to approve a resolution sustaining ISMS objections to the concept of random substitution of prescription products, but permitting the Board to seek restrictive amendments to generic prescription legislation which passage seems imminent.

## **Amendment to S.B. 947**

Should attempts be made by the Legislature to amend S.B. 947, which requires Public Aid providers to disclose their financial status, ISMS will attempt to limit such disclosure to direct ownership in health care facilities providing such services.

## **Good Samaritan Concept for Emergency Situations**

ISMS will seek to extend the Good Samaritan concept to all emergency situations within a hospital so long as the person giving emergency care does so without prior notice of the injury and without compensation.

## **20/40 Legislation**

Should legislation be introduced to permit optometrists to use drugs, ISMS will seek an amendment requiring that any person whose eyesight tests below 20/40 be immediately referred to a physician for any further treatment.

## **Insurance Laws Study Commission**

A legislative proposal of the Insurance Laws Study Commission—which would seek to regulate physicians' fees under a proposed health care commission—will be opposed by ISMS.

## **Amendments to Controlled Substances Act**

ISMS will seek to amend the Controlled Substances Act so that possession of any amount of cocaine, morphine or heroin without a prescription would be illegal.

## **Heeds Program**

The Board approved in principle support for legislation which would provide full funding for health education programs in Illinois. Full approval was withheld pending receipt of information regarding the amount of funds requested.

## **Informing the Membership**

The House of Delegates will be urged to establish a policy stipulating that the membership has been properly informed of any House action when the following have been accomplished:

(1) Official notice in the Illinois Medical Journal; (2) Brief notice in Action Report, outlining the issue and calling attention to the IMJ article, and (3) Letter sent to all county society presidents, secretaries and county society executives.

## Death With Dignity

ISMS will continue to oppose death with dignity legislation, based on what must necessarily be a private matter between physician and patient.

## Hypertension Control

The Board agreed not to support proposed legislation calling for the establishment of a Hypertension Registry in the Illinois Department of Public Health. The proposal was developed by the Ad Hoc Committee for an Illinois Program to Control High Blood Pressure, of which ISMS is a sponsoring organization. Because the committee's legislative proposal is unacceptable, ISMS will withdraw as a sponsoring organization.

## Heimlich Maneuver

ISMS will support H.B. 13, a bill which would require that posters explaining the Heimlich Maneuver be placed in all restaurant kitchens.

## Licensing

ISMS will seek amendments to the Medical Practice Act to: (1) Provide a two-year graduate clinical training permit for individuals who hold a medical degree and have been accepted into an approved residency training program; and (2) Allow Illinois residents and those wishing to practice in Illinois to receive a temporary license. The Department of Registration and Education will be asked to develop an application form for use by medical schools in recruiting foreign doctors from whom they wish to have the required 12 months clinical training waived.

## Physician's Assistants

ISMS will oppose hospital employment of physician's assistants and any modification in the Physician's Assistant Practice Act.

## Leadership Conference

Health care costs and other major issues will be the focus of the ISMS Leadership Conference, Mar. 19, at the Marriott Motor Hotel, Chicago. Featured speakers will be John Virts, Ph.D., Eli Lilly & Co., corporate staff economist who will discuss causes of increased health spending, and Dr. Joseph Von Thron, trustee of the American Medical Political Action Committee. The conference is planned primarily for county and specialty society officers and ISMS and AMA delegates. Society officers and committee chairmen will serve as faculty for a series of workshops offering an in-depth analysis of legislation . . . medical discipline . . . health planning and professional liability.

## Nominees For State Positions

ISMS has forwarded the following nominations for state positions:

### *Medical Examining Committee of Illinois Department of Registration and Education (5 to be appointed)*

Joseph L. Bordenave, M.D., Geneva  
Louis Dondanville, M.D., Moline  
James P. FitzGibbons, M.D., Chicago  
C. Larkin Flanagan, M.D., Chicago  
David S. Fox, M.D., Chicago  
Jack Gibbs, M.D., Canton

E. E. Hasbrouck, M.D., Chicago  
Robert P. Johnson, M.D., Springfield  
Richard L. Landau, M.D., Chicago  
William M. Lees, M.D., Lincolnwood  
Richard N. Rovner, M.D., Chicago  
P. John Seward, M.D., Rockford

### *Illinois Health Facilities Planning Board*

First Vacancy—Boyd McCracken, M.D., Greenville  
(presently nominated and waiting Senate confirmation)  
Second Vacancy—Audley Connor, Jr., M.D., Chicago



# The Panel for the Impaired Physician

BY MARIANN MCGUIRE, IMJ ASSISTANT EDITOR

*In recognition of a significant problem, the ISMS Board of Trustees has authorized implementation of a plan, proposed by the ISMS Committee on Alcoholism and Drug Dependence, to aid physicians suffering from alcoholism and drug addiction.*

"I am that common but rarely mentioned problem, the drug-addict doctor. Depending on whom you talk to, I am an amoral bum, an ill-used and tragic figure, an embarrassing statistic, a blameless sick man, or a disgrace to the profession.

"Actually, I am none of these things, or perhaps a little bit of all of them, but eight years of fighting the problem have made one thing discouragingly clear: the most enlightened medical profession that civilization has ever known, in the wealthiest country in history, doesn't know how to treat me, and really doesn't want to know."<sup>1</sup>

The problems of doctors addicted to drugs (including alcohol) have been recognized for years, but only in this decade has the medical profession acknowledged their magnitude. The issues that have emerged demonstrate beyond contradiction that physicians are subject to a unique combination of external pressures and internal anxieties that relegate mental illness and addiction to the category of occupational hazards.<sup>2</sup>

A 1972 study (Vaillant *et al.*) documented the activities of 47 medical students through 30 years of adult life. The researchers found that 47% experienced bad marriages or divorce, 36% used drugs for relief, 34% sought psychotherapy and 17% underwent psychiatric hospitalization.<sup>3</sup>

A 1967 study (DeSole *et al.*) estimated that 26% of all physician deaths between the ages of 25 and 39 are suicides, in contrast with a 9% incidence for non-physician males in the same age group.<sup>4</sup> According to a report by the AMA Department of Mental Health, "One medical school graduating class of 100 students is needed each year to replace physicians who commit suicide."<sup>5</sup>

AMA President Richard E. Palmer, speaking at the second National AMA Conference on the Impaired Physician (Feb. 1977), reported that

approximately 17,000 American physicians suffer from addiction or mental illness. Other speakers offered estimates as high as 10% of all practicing physicians.<sup>6</sup>

The assertion that addiction is the major manifestation of psychiatric illness in physicians, and that M.D.'s are peculiarly vulnerable to the disease, appears to be sound.<sup>7</sup>

James W. West, M.D., Co-Chairman of the ISMS Committee on Alcoholism and Drug Dependence and Chairman of the ISMS Panel for the Impaired Physician, has worked with physician-addicts for over 25 years. According to Dr. West, misconceptions about alcoholism and its victims are responsible for the lack of progress in prevention and treatment.

"Most of the alcoholics in the United States aren't the skid row bums we see in the movies," Dr. West said. "They are highly gifted, intelligent and achievement-oriented people. Some of the most respected and influential members of our society are alcoholic, and have suffered from the disease since they were in their teens. At least half of the six Americans to win the Nobel Prize in literature in this century were victims of alcoholism and demographically speaking, *that* is a representative sample."

## Intent and Purpose

At this writing, more than 28 states have initiated some program to aid the "sick doctor."

The ISMS Panel for the Impaired Physician is composed of 16 doctors, all of whom are experienced in treating physicians suffering from mental illness or addiction to alcohol and other drugs. Members of the Illinois Recovered Physicians Association are anxious to add their help. They can offer "physician-patients" the benefit of personal experience.

Every member of the Panel is a volunteer. All

are committed to seek out those in need of aid and assist them through a physician-patient relationship within the confines of absolute confidentiality.

"The Panel," Dr. West said, "is simply a group of doctors who have volunteered to help a troubled person in the spirit of the medical fraternity. We intend to provide help at every possible level on the single condition that the physician is willing to do his part to help himself."

---

***One cannot produce an alcoholic by making him drink. Before he ever takes his first drink, predisposing factors have established the basis for his addiction.***

---

Although the Panel includes eight psychiatrists experienced in treating mentally ill physicians, addiction is the prime target. "Most mentally ill people will seek professional help on their own," Dr. West said. "Few doctors can continue to practice in the presence of severe depression. It is the addicted doctor who has been lead to believe that he should be embarrassed and ashamed, and who needs an impetus to recognize his problem and find professional help."

Doctors abusing narcotics are likely to be identified through state prescription audits before their impairment becomes evident to others. Those who do come to the Panel will share much in common with physicians addicted to alcohol. The treatment is not dissimilar.

Most alcoholic physicians will also abuse other drugs—if only to treat their own symptoms. "Almost every physician who is alcoholic is also abusing non-narcotic drugs," Dr. West noted.

The Panel anticipates that alcoholism will emerge as the most common problem. At a national level, it has been estimated that 2/3 of impaired physicians are specifically addicted to alcohol.<sup>8</sup>

The Panel members will work as aides and advocates of the disturbed doctor, to preserve his dignity and his anonymity with an absence of legal or moral sanction. The addicted physician must be convinced that he has no reason for embarrassment or guilt before he will accept his addiction as an illness.

"The physician must come to realize that alcoholism and drug addiction are illnesses," Dr. West said. "That the disease is not in the bottle but in the person. One cannot produce an alco-

holic by making him drink. Before he ever takes his first drink, predisposing factors have established the basis for his addiction."

"It is the Panel's job to help the impaired physician understand that addiction is no more his fault than if he had diabetes," Dr. West continued. "That it is a chronic psycho-biological disease with prominent genetic components, but also a condition which can be remedied. That realization is the prime target and the biggest challenge in treating a disabled physician."

The Panel, as established by ISMS, is intent upon preserving the foundation of confidentiality and friendship. The Panel does not propose to implement a coercive program. Its role is to help the doctor recognize his problem and motivate him to seek voluntary treatment. Panelists will offer the encouragement, compassion and understanding of one peer to another.

### **The Nature of the Disease**

Addiction may be defined as an increased tolerance to a given drug, accompanied by withdrawal symptoms when the drug use is discontinued. It is insidious by nature, and most often unrecognized until physical symptoms assert themselves. It is inevitably progressive and exquisitely predictable.

Most persons enter alcoholism treatment in their early forties. It is probable, according to Dr. West, that they have been alcoholic for at least 15 years, but have denied the problem until symptoms of decompensation began to emerge. The process is very much the same in narcotic addiction, with the single exception that physical deterioration is usually less rapid.

Alcohol and narcotic addictions are characterized by recognizable stages of dependency. A psychological dependency asserts itself in early years, followed by increased tissue tolerance for the drug. Progression of the illness follows. With the passage of time, tissue tolerance gradually decreases and physical addiction (accompanied by liver damage, brain dysfunction, etc.) becomes a dominating force in the addict's life.

The final stage of addiction is often death, through physical complications or suicide. It was estimated in one study that 40% of physician suicides between May of 1965 and November of 1967 could be directly attributed to abuse of alcohol and other drugs.<sup>9</sup>

### **Why Doctors?**

The disproportionate representation of physi-

cians in demographic samplings of addicts<sup>7</sup> is rooted in a number of factors. The dynamic proposed by one group of researchers compounds personal and professional causes.<sup>10</sup>

The physician works in a state of sustained stress. Despite his medical training, or perhaps because of it, he is prone to a contempt for the addictability of drugs.

He fulfills the role of a "tower of strength" while prescribing drugs for patients who share his symptoms. Self-diagnosis implies the same prescription.

The typical physician leads a harried existence with irregular sleeping schedules and constant underlying fatigue. Tension and insecurity are frequent byproducts, and personal relationships often suffer.<sup>11</sup>

Addiction, as an insidiously gradual impairment, may mask itself as overwork, chronic fatigue or another physical disorder.<sup>12</sup>

Feelings of isolation and fears of lost respect from both patients and colleagues feed his psychological dependency until it reaches the physical stage. If he does suspect the true nature of his discomfort, the impaired physician is usually "phobic about asking for help."<sup>13</sup>

---

*It has been estimated that 2% of the physicians now practicing in Illinois are addicted to narcotics. Approximately one in every ten Illinois doctors who drink has an alcohol related problem.*

---

Physicians have proven characteristically reluctant to admit to disturbances of this nature. Medical school training and professional experience have placed them in the role of invincible healers, and forced them to ignore their own psychological needs. Addiction is perceived as a professional failure.<sup>14</sup>

The Panel seeks to provide objective and confidential referral for troubled physicians to sources of treatment and roads to recovery. Members will act as advocates throughout the rehabilitation process to smooth the route from addiction to cure and re-entry into the profession. They are determined to remove the moral stigma associated with these problems.

### **The Mechanism**

The Panel members' names and home telephone numbers are included in a pamphlet to be mailed to the home of every physician in Illinois (see map). The use of home telephone numbers

rather than office numbers is designed to ensure further protection of the patient-physician's privacy.

The doctor himself will rarely contact the Panel, largely because the nature of the disease prohibits self-diagnosis. Some referral calls originate from colleagues, or concerned superiors.

But most calls, Dr. West explains, come from the family of the sick doctor. Concerned spouses have often watched their mates become increasingly ill, but felt that any action on their part would endanger their husbands' careers.

---

*If he does suspect the true nature of his discomfort, the impaired physician is usually phobic about asking for help.*

---

The Panel for the Impaired Physician eliminates this danger. The troubled doctor can only be helped. No sanctions are imposed. No records are kept. No reports are made. If the doctor refuses help, no coercion is employed. Absolute privacy is ensured.

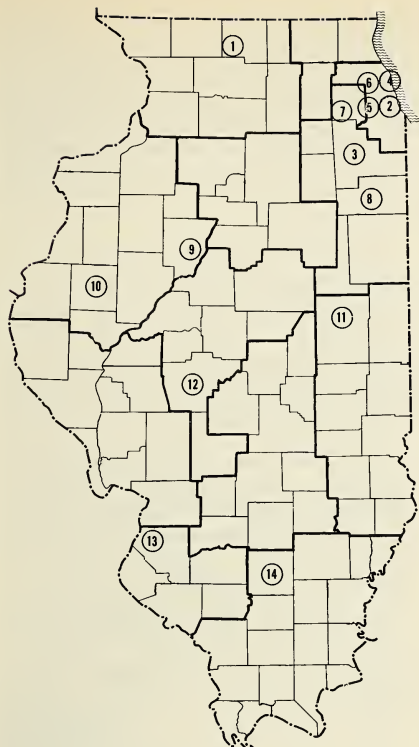
Concerned friends may call any member of the Panel. They will be required to identify themselves, in order to screen frivolous or malicious calls. The referring party is guaranteed absolute anonymity, if so desired, but frequently becomes involved in the treatment process.

As a totally confidential, non-punitive body, it is expected that the Panel will receive referrals from hospital administrators who wish to avoid disciplinary action. In addition, the Panel will be available to the Department of Registration and Education for treatment referral. Any physician brought before this licensure body because of impairment due to alcohol, drugs or mental illness can be referred to the Panel for help. Although the Panel for the Impaired Physician has no official ties to state licensing agencies, it will accept physician referral from these agencies for treatment.

### **Treatment**

The treatment process has five stages: (a) education of the nature of the impairment; (b) individual counseling; (c) rehabilitation as an outpatient or inpatient; (d) re-entry into medical practice; and (e) ongoing maintenance therapy.

When it is determined that a problem does exist, the Panel member, along with perhaps a second member and a recovered physician, may form an intervention team to visit the doctor personally.



## THE PANEL FOR THE IMPAIRED PHYSICIAN

1. David Stinson, M.D.  
Rockford ..... 815-964-5050
2. James W. West, M.D.—Chairman  
Chicago ..... 312-238-8708
2. Edward Senay, M.D.  
Chicago ..... 312-663-3611
3. Alex J. Spadoni, M.D.  
Joliet ..... 815-725-6511
4. Donald Greaves, M.D.  
Evanston ..... 312-492-3913
5. W. David Steed, M.D.  
Oak Park ..... 312-386-5098
6. Nelson J. Bradley, M.D.  
Park Ridge ..... 312-696-6066
7. William J. Weigel, M.D.  
Aurora ..... 312-892-4244
8. Reinhold Schuller, M.D.  
Kankakee ..... 815-937-2412
9. Richard Lee, M.D.  
Peoria ..... 309-676-2616
10. John Goncher, M.D.  
Macomb ..... 309-836-9211
11. Dorothy Schultz, M.D.  
Champaign ..... 217-352-0518
12. Albert S. Norris, M.D.  
Springfield ..... 217-782-5880
12. Terry A. Travis, M.D.  
Springfield ..... 217-782-5880
13. René Saint-Leger, M.D.  
East St. Louis ..... 618-274-2111
14. Goff Thompson, M.D.  
Mt. Vernon ..... 618-244-2411

At that meeting, they conduct a diagnostic assessment interview. The diagnosis of alcoholism is based on a clinical history, which may or may not be accompanied by physical signs.

### Education and Individual Counseling

Once he understands the clinical nature of his condition, the "physician-patient" most often becomes an enabler, a willing participant in his treatment and recovery. Confronted about obvious changes in his behavior, the physician is almost always anxious to begin treatment. He comes to recognize that his addiction is a handicap to his family and his patients. The sense of professional responsibility, long attenuated by periods of debilitation, confusion and denial, is reawakened.

Although more than one visit is sometimes necessary to convince the impaired physician, it has

been the experience of Panel members that very few doctors refuse help.

"The troubled doctor can see that family and friends are genuinely concerned for his welfare," Dr. West said. "He knows the intervention team has no motivation other than helping him; that it is made up of volunteers who have experience in treating disturbed physicians." The fact that so many people are offering to help in a firm and compassionate manner is almost always sufficient to end his denial.

If the doctor refuses treatment, the Panel members will continue their attempts to help him. They will not, however, betray his confidence. His decision to avoid treatment will be respected.

### Rehabilitation

Ideally, the entire family of the impaired phy-



sician will enter therapy. Family therapy, with the doctor's permission, is a fundamental goal of the program.

Most impaired physicians have troubled marriages as well. The ISMS Auxiliary has expressed its desire to play an important role in the program for this "medical family illness." It has been found that the recovery rate for physicians whose families become involved in the treatment process is 15% higher than that of doctors who seek rehabilitation without filial support.

The impaired doctor may be asked to enter a hospital for inpatient rehabilitation treatment. The Panel members have found that the doctor benefits by seeking treatment outside his community. Inpatient rehabilitation in a recognized treatment center may be indicated.

Most third party payors, Dr. West said, will provide for addiction programs. In addition, free treatment is available at some rehabilitation programs for the indigent physician.

### **Ongoing Maintenance Therapy**

Although addiction has a traditionally high rate of recidivism, Dr. West said, this has not been the experience with physicians treated by doctors on the Panel. This may be due, in part, to the continued support of Panel members after recovery has been achieved.

The recovered physician is also encouraged to join the Illinois Recovered Physicians Association as a part of his ongoing maintenance therapy. The Recovered Physicians provide encouragement and advice, and membership enables the rehabilitated physician to help others with the benefit of his experience. Alcoholics Anonymous plays a role with most who maintain permanent recovery. In addition, a large percentage are involved in formal psychotherapy.

### **Resuming Practice**

A fear of losing face—or patients—is a major factor in treatment avoidance. Physicians express anxiety about community response upon their return, should the nature of their illness become known. The Panel endeavors to help with his re-entry and the reestablishment of professional practice.

The Panel will try to help in rebuilding any lost professional respect. In one instance, Dr. West related, the physician's hospital administrator refused to permit a recovered physician to rejoin the staff. A visit to the administrator served not only to open lines of communication about

the problems of addicted doctors, but also to reinstate the physician.

"I went to the hospital," Dr. West said, "and told the administrator that the man had been sick; that those transgressions of medical care were symptoms of his illness. Because I had been involved in his recovery, I accepted responsibility for his actions. The administrator agreed to our arrangement, and has since assured me that the doctor is among the best in his specialty within the entire hospital."

Such difficulties, however, have proven to be rare. Despite fears of patient distrust, the opposite is frequently the case.

"It has been our experience that few patients will change doctors. They were probably aware of the problem long before it was treated," Dr. West said. "They're happy for his recovery. Recovery is seldom a problem. The best treatment for maintaining recovery is the return to work."

---

*The recovery rate for physicians whose families become involved in the treatment process is 15% higher than that of doctors who seek rehabilitation without filial support.*

---

The question of malpractice insurance for recovered M.D.'s has been resolved. Two members of the Committee on Alcoholism and Drug Dependence met with the Illinois State Medical Inter-Insurance Exchange and formed an agreement on their patients' behalf. The recovered physician need not be concerned about the additional penalty of greatly increased malpractice premiums. His documented recovery will place him at normal risk.

### **Membership Responsibility**

A major hurdle faced by the program is what has been termed the "conspiracy of silence" within the medical profession itself.<sup>16</sup>

Due to their own vulnerability, or perhaps to a judgmental orientation, colleagues often fail to seek help for peers who can no longer help themselves. It is precisely this reluctance that prolongs the cultural stigma so little deserved by victims of addictive disease.

Typically observed symptoms in early alcohol dependence include a preoccupation with alcohol accompanied by a high tolerance for the drug. Drinking inappropriate amounts of alcohol at inappropriate times with physical signs of intoxication or evidence of withdrawal phe-

nomena, (e.g., tremors,) are diagnostic of the illness.

It is the duty of those physicians and persons close to an impaired doctor to recognize these symptoms of his illness and to help him confront it before the addiction becomes physically disabling. The Panel for the Impaired Physician can provide consultation and help with this confrontation.

### Conclusion

It has been estimated that 2% of the physicians now practicing in Illinois are addicted to narcotics. Approximately one out of ten Illinois doctors who drink has an alcohol related problem.

The profession has recognized that the parallel duties to patient and colleague are mutually dependent. Organized medicine must accept as its paramount responsibility an accountability to the public for competent professional care.<sup>5</sup> As one physician has said:

"We must show that we can deal with the problem in an intelligent and humane way, and that the medical professional can take responsibility for itself."<sup>17</sup>

### References

A complete list of references for "The Impaired Physician" may be obtained by writing the Illinois Medical Journal, 55 E. Monroe, Suite 3510, Chicago, 60603.

## Viewbox

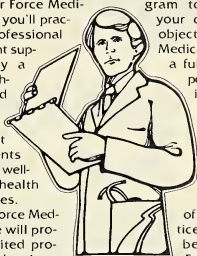
(Continued from page 252)

**DIAGNOSIS:** *Acute Pyelonephritis of the Right Kidney*—The significant findings on the initial pyelogram are diminished density of the collecting system on the right side compared to the left side. There is some distortion and attenuation of calyces. The intensity of the nephrogram of the left kidney appears to be greater than that of the right side. It is also noted that the renal outline on the right appears slightly hazy when compared to the left. On the basis of the radiographs, a diagnosis of acute pyelonephritis was made. This was later confirmed by the appearance of white cell casts in the urine when a nephrologist reviewed the specimen. A repeat IVP five weeks later reveals some interesting findings, the right kidney system is definitely reduced in size when compared to the left. The collecting system was well visualized, however. At this time the patient is asymptomatic.

## Physicians: we treat you seriously in the Air Force

As an Air Force Medical Officer, you'll practice in a professional environment supported by a team of highly qualified technical assistants. You'll treat your patients in modern, well-equipped health care facilities.

The Air Force Medical Service will provide unlimited professional development, with a carefully designed individual pro-



gram to complement your own skills and objectives. Air Force Medical Centers offer a full range of opportunities in clinical medicine, including clinical investigation.

Avoid the time consuming burdens of private practice. Consider the benefits of Air Force medicine. Health care at its very best.

Capt. Dave Johnson, Medical Officer  
12th & Spruce Streets  
St. Louis, MO 63102  
Phone Collect (314) 268-2471

Air Force. A great way of life.

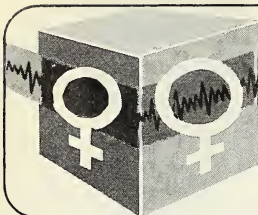
In a review of 40 cases of acute pyelonephritis Silver,<sup>1</sup> et al found 11 with abnormal IVPs, the following findings occurred in these cases in varying numbers.

1. Diminished nephrogram density
2. Delayed calyceal appearance time
3. Diminished calyceal density
4. Slight calyceal or pelvic dilatation on the involved side
5. Distorted (attenuated, spastic, or displaced calyces)
6. Renal enlargement was a prominent feature.

It is possible that our case demonstrating the small kidney 5 weeks later had a swollen small kidney on the initial study which returned to its contracted size following successful treatment of the infection.

### Reference

1. Silver, et al, Radiology, 118, pp. 65-71, 1976.



*pulse...* of the doctor's wife

Mrs. HAROLD KEEGAN, Editor

## AMAA Plans Annual Meeting

### *Educational and Social Events Scheduled*

The American Medical Association Auxiliary, Inc., has announced a schedule of events for their annual convention, to be held June 19-22 at the San Francisco Conrad Hilton. The convention, which is open to all auxiliaries, will feature meetings and speakers on a wide variety of educational and social issues.

On Sunday, June 19, at 2:00 p.m., the opening session of the House of Delegates will feature Dr. Tom Haggai, whose syndicated radio program, "Values for Better Living" is aired daily across the nation.

The opening House session will also host Richard E. Palmer, M.D., AMA president, and James M. Blake, M.D., president of AMA-ERF.

Two educational programs are scheduled prior to the opening of the first session. Beginning at 10:15 a.m., the AMA Council on Continuing Physician Education will sponsor two simultaneous seminars. The first, "How to Start to Stop: A Physician's Guide to Retirement", will be conducted by Gerald Farley, Assistant Director of the AMA Department of Practice Management. Mr. Farley will detail the technicalities in closing a medical practice. The second seminar concerns "Facts, Fads, and Fancies about Plastic, Reconstructive and Maxillofacial Surgery".

Monday's business sessions will address the annual budget, membership awards, and the annual report of the Board of Directors. Nominations and election of the 1978 nominating committee and an idea exchange of outstanding state projects are also scheduled.

A new convention feature will be initiated on Tuesday morning, and will be open to all members. Open forums to discuss national membership recruitment and dues collection, as well as proposed amendments to the bylaws, should en-

gender strengthened communication within the AMAA. The communication committee will also conduct a workshop on Tuesday, designed to facilitate interchange between auxiliaries and medical societies.

Wednesday, June 22, formal installation of new officers will be undertaken. Mrs. Chester L. Young, 1977-78 president, will present the inaugural address, and a reception sponsored by the Kansas Medical Society Auxiliary will follow.

On Sunday evening an annual reception will be held in honor of Mrs. Norman H. Gardner, auxiliary president, and Mrs. Chester L. Young, auxiliary president-elect.

Two prominent specialists will speak at open luncheons. At Monday's meeting, William F. Buckley, Jr., well known author, editor and television personality, will address "Some of the Problems of Freedom." On Tuesday, Albert B. Sabin, M.D., who developed the oral attenuated polio virus vaccine, will discuss "Immunization."

The convention will close with a reception on Wednesday evening hosted by the AMA in honor of John H. Budd, M.D., 1977-78 AMA president and Mrs. Chester L. Young, 1977-78 auxiliary president.

The AMAA has urged all auxiliaries to avail themselves of the many educational opportunities and cultural events of the annual convention. Reservation forms for the hotel appeared in the winter issue of *M.D.'s WIFE* and will again appear in the spring issue. Special event reservation forms are included therein.

The San Francisco Hilton Hotel and Tower at Mason and O'Farrell Streets will serve as Auxiliary Headquarters. Registration begins at 8:30 a.m., Saturday, June 18, and will continue until 1:00 p.m. on Wednesday, June 22.

# Contraceptive Knowledge and Customs: A Study

By ROGER BISHOP, M.D./MARION

Knowledge, customs and effectiveness of contraceptives in use in the Springfield, Illinois area have not been studied recently. Despite its importance, this is a subject which is not usually considered with care in Family Practice courses. I therefore decided to investigate what methods were in use in the Southern Illinois University Family Practice Center in Springfield, and measure acceptability. An additional outcome of the study was an evaluation of the extent of need for further patient education in this subject. Studies elsewhere have indicated that despite much information put before the public by the popular press, there is nevertheless a major part of the population who have little or no understanding of modern, effective contraception. Relating this to the problems of unplanned pregnancies, child abuse and population problems, the most appropriate person for delivery of contraceptive education and material is the family physician.

## Materials and Methods

A questionnaire was designed with the help of Dr. L. Adler, Professor of Sociology at SIU, and a pilot trial was conducted to establish that the question and format were practicable and the study feasible. The questionnaire was given primarily by myself and third year residents at the Family Practice Center in Springfield, to women between the ages of 18 and 55, and men aged 18 and older. This was done during random office visits and routine history and physical

examinations, with the exception of office visits for acute life threatening illnesses.

## Results

A total of 106 questionnaires were given to individual patients over a period of three months between November, 1975 and January, 1976.

**Table 1** is an illustration of the most popular methods of contraception presently in use. *The most striking finding here is that 29% of the total survey population used oral contraceptives.* This is very close to the estimated value of thirty percent of women in the United States between the ages of 18 and 44 using the oral contraceptive (Kase, et. al.<sup>1</sup> 1975). *The other striking finding here is that 10% of the population was pregnant.* This most likely represented the young age group in our patient population.

TABLE 1

### Most Popular Methods Presently

Method	Number	Percent
1. Oral Contraceptives	31	29
2. Inactive (none)	12	11
3. Pregnant	11	10
4. Hysterectomy	10	9
5. Vasectomy	8	7
6. I.U.D.	6	6
7. Foam	5	5
8. Condoms	5	5
9. Attempting Pregnancy (none)	5	5
10. Tubal Ligation	4	4
11. I.U.D. + Foam	2	2
12. Diaphragm	2	2
13. Condom or		
Oral Contraceptives	1	1
14. Rhythm + Foam	1	1
15. Withdrawal or		
Oral Contraceptives	1	1
16. Rhythm	1	1
17. Infrequent Activity (none)	1	1
	106	100

ROGER BISHOP, M.D., is a specialist in family practice and obstetrics. Dr. Bishop served his residency at the Southern Illinois University St. John's Hospital in Springfield and was a resident member, Illinois Academy of Family Physicians' Student Committee.





**TABLE 2**  
**Most Popular Methods Among Singles**  
**47 of 106 were single (44.3%)**

Method	Single	Separated	Divorced	Widow	Total	Percent
1. Oral Contraceptives	10	1	2	0	13	28
2. Inactive (none)	7	0	2	1	10	21
3. Hysterectomy	0	0	5	1	6	13
4. Pregnant	1	3	0	0	4	9
5. Condom	3	0	0	0	3	6
6. I.U.D.	2	0	1	0	3	6
7. Foam	2	0	0	0	2	4
8. Tubal Ligation	0	0	2	0	2	4
9. Diaphragm	1	0	0	0	1	2
10. Vasectomy	0	0	1	0	1	2
11. Condom or Oral Contraceptives	1	0	0	0	1	2
12. Withdrawal or Oral Contraceptives	1	0	0	0	1	2
	<u>28</u>	<u>4</u>	<u>13</u>	<u>2</u>	<u>47</u>	

**Table 2** is an analysis of the methods in use among singles. Forty-seven of the 106 patients (44.3%) interviewed were single. This table again shows that the oral contraceptives are by far the most popular, with 28% using them. This is almost the same as the 29% in the general population. It was interesting to note that 21% of the population in this group claims to be sexually inactive as compared with 11% overall. The majority of these patients were single. This may reflect the young age group in our practice.

**Table 3:** I was also interested in what proportion had tried something before their present method of contraception, and the reasons for change from previous methods of contraception. It is interesting that 77 of 106 patients (73%) had tried other methods of contraception prior to their present method. This obviously shows that there had been much switching from various methods. The reasons for change are variable. There were 130 total reasons given for change, and 52 of these were concerned with the oral contraceptive. By far the highest reasons given were: headaches, fear of "problems," and emotional problems. The highest individual complaint was 16 people stating that condoms were "unnatural." Ten people also stated that foam was "unnatural." As far as unwanted pregnancies are concerned, the data shows that there were five unwanted pregnancies while foam was in use, four while the diaphragm was in use, three while rhythm was in use, two while the IUD was in use, and one while the condom

was in use. *This appears to be a quite high failure rate for all methods listed except the oral contraceptive.*

**Table 4:** I was also interested in the number of patients that stopped their chosen methods. The highest percentage once again was the oral contraceptive with 36% of the total number of changes. This represented 52 of 146 changes that had occurred among this patient population. The next highest was 18% of the total number of changes (27 changes) with the condom.

**Table 5** is a correlation of the size of the index family with the present family and the planned family size. The index family is listed as the number of siblings. There were 174 total patients listed here since this includes the marital partner of those involved in the study. There were a total of 82 different listings with the most common categories being an index family of one with two in the present family and two planned, two in the index family with two in the present family and two planned, and three in the index family with two in the present family and two planned. These were ten, eleven, and eight people respectively. Grouping data from number 56 and number 78 seems to show that if a large family is wanted, a large family can be expected! This table as a whole seems to show that contraception is working to a certain extent and achieving its objective. However, the question arises as to whether a prospective study would show the same as this retrospective data.

TABLE 3

77 of 106 (73%) had Tried Other Methods  
Before the Present Method

## Reasons For Change:

*Oral Contraceptives.*

Headaches	9
Fear of Problems	8
Emotional Problems	8
Weight Gain	5
Increased Menstrual Flow	5
Cycle Irregularities	4
Leg Cramps	3
Uncertainty if Missed A Pill	2
Nausea	2
Dyspareunia	1
Breast Tenderness	1
Hypertension	1
Vaginal Infections	1
Fibroids	1
Varicose Veins	1

52

*Condoms.*

Unnatural	16
Unreliable	5
*Pregnant	1

22

*Foam.*

Unnatural	10
*Pregnant	5
Unreliable	4
Expensive	1

20

*I.U.D.*

Cramps	6
Increased Menstrual Flow	2
Cycle Irregularities	2
*Pregnant	2
Dyspareunia	1
Unreliable	1
Fear of Infection	1
"Fell Out"	1

16

*Diaphragm.*

Unnatural	7
*Pregnant	4
Unreliable	1

12

*Rhythm.*

*Pregnant	3
Unreliable	3
Inconvenient	1

7

*Cream.*

Dyspareunia	1
-------------	---

130 Total Reasons Given For Change.

TABLE 4

Number Stopping Certain Methods

Method	Number	Percent of Total No. of Changes
Oral Contraceptives	52	36
Condoms	27	18
Foam	20	14
I.U.D.	16	11
Diaphragm	12	8
Rhythm	9	6
Cream	5	3
Douche	1	1
Abstinence	1	1
Vasectomy	1	1
"Fertility Tester"	1	1
"Home Recipe"	1	1
146 changes		

trends of any significance. Finally, I also wanted to correlate the occupation of the head of the household, defined as the male marital partner, with the present method of contraception.

Table 7: Class I represents unskilled or manual labor or the unemployed. Class II represents skilled labor. Class III represents professional, executive or managerial people. Class IV was nonclassifiable in that there was no male marital partner. This revealed some interesting data. Forty percent of the Class I people were using no contraception, and thirty percent were pregnant. In Class II 44% were using the oral contraceptive, and only six percent was pregnant. Also, in Class II only 16% were using none. In Class III only five percent were using no contraceptive, and 28% were using the pill while 12% were pregnant. It is very interesting to note that seven of the eight patients who were vasectomized were in Class III, and four of the six who were using condoms were in Class III.

## Discussion

The study seems to indicate that the oral contraceptive is still the most popular method of contraception in spite of many complaints and much switching. It also appears that contraception is working to a certain extent whatever method is used. However, the need for patient education was clearly shown, especially in lower socioeconomic groups. The information obtained here showed the value of routine questioning of all new patients about contraceptive needs as part

**Table 6:** I also wanted to correlate the level of education with the present method of contraception. Here there appear to be no marked

of the overall health history. The study itself poses the question as to whether truly satisfactory contraceptive methods are presently being used or indeed are available. I intend to continue this study and expand it to include a comparison of a rural area in southern Illinois with further data from the University Family Practice Center in urban Springfield.

### Summary

A study of contraceptive knowledge and practice carried out by questionnaire in a midwestern

town reveals the need for patient education and desirability of family physician involvement in contraception. The most popular agent is the oral contraceptive pill which has, nevertheless, many drawbacks. ◀

### Reference

1. Kase, N. G., Spallacy, W. N., Chez, R. A., Paulsen, C. A., Queenan, J. T., and Mishell, D. R.: *Oral Contraception*, November 1975.

TABLE 5  
Correlate Size of Index Families with Present and Planned Families

	Index (siblings)	Present	Planned	No.		Index (siblings)	Present	Planned	No.
1.	0	0	0	3	42.	4	0	0	2
2.	0	1	2	1	43.	4	0	1	4
3.	0	2	2	1	44.	4	0	3	1
4.	0	3	3	1	45.	4	0	4	1
5.	0	7	7	1	46.	4	1	1	1
6.	1	0	0	4	47.	4	1	2	2
7.	1	0	?	3	48.	4	1	3	1
8.	1	0	1	3	49.	4	1	5	1
9.	1	0	3	1	50.	4	2	2	1
10.	1	1	1	2	51.	4	2	4	1
11.	1	1	2	3	52.	4	3	3	2
12.	1	1	3	2	53.	4	4	4	3
13.	1	2	2	10	54.	4	5	5	1
14.	1	2	3	2	55.	4	6	6	1
15.	1	3	3	3	56.	4	12	12	1
16.	1	4	4	5	57.	5	0	0	1
17.	1	5	5	1	58.	5	0	?	5
18.	1	6	6	1	59.	5	0	3	1
19.	1	7	7	1	60.	5	1	?	1
20.	2	0	0	3	61.	5	1	1	1
21.	2	0	?	4	62.	5	1	3	1
22.	2	0	1	2	63.	5	2	2	2
23.	2	0	2	3	64.	5	3	3	2
24.	2	1	2	6	65.	6	1	3	1
25.	2	1	3	3	66.	6	2	2	1
26.	2	1	5	1	67.	6	4	4	1
27.	2	2	2	11	68.	7	0	3	1
28.	2	2	3	6	69.	7	1	2	1
29.	2	3	3	2	70.	7	2	2	2
30.	2	5	7	1	71.	7	5	7	1
31.	2	6	6	1	72.	8	1	2	2
32.	3	0	0	1	73.	8	2	3	2
33.	3	0	1	3	74.	8	3	4	1
34.	3	0	2	1	75.	9	2	2	1
35.	3	1	1	3	76.	9	4	4	1
36.	3	1	2	3	77.	10	4	4	2
37.	3	1	10	1	78.	10	12	12	1
38.	3	2	2	8	79.	11	1	?	1
39.	3	2	3	1	80.	11	2	2	1
40.	3	3	3	1	81.	11	5	5	1
41.	3	3	4	2	82.	13	6	6	1

**TABLE 6**  
**Correlate Years of Schooling with Present Method**

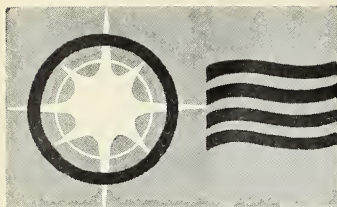
Years of Schooling	Condoms	I.U.D.	None	O.C.'s	Foam	Pregnant	Rhythm	Diaphragm	Withdrawal	Vasectomy	Hysterectomy	Tubal Ligation	Totals
12											1		1
6						1							1
7						1							1
8			1										
9			2								1	1	3
10			3	1		2				1			7
11											1		1
12		2	6	11	1	3	2				3	1	29
13 (L.P.N.)	1		1	4							2		8
14				7	2	1				1	1	1	13
15 (R.N.)	1		1	1				1		1	1		6
16 (B.S.)	3	2	3	7	1	3				2		1	22
17	1												
18 (M.S.)		1		2	1			1	1	1			7
19					1					1			2
20 (Ph.D.)		3	1		2					1			7
Totals	6	8	18	33	8	11	2	2	1	8	10	4	

**TABLE 7**  
**Correlate Occupation of Male Marital Partner (Head of Household) with Present Method**

Class I = unskilled, manual, unemployed  
 Class II = skilled labor  
 Class III = professional, executive, managerial  
 Class IV = non-classifiable (no male marital partner)

	Condoms	I.U.D.	None	O.C.'s	Foam	Pregnant	Rhythm	Diaphragm	Withdrawal	Vasectomy	Hysterectomy	Tubal Ligation	Totals
I			4	1		3					1	1	10
II	1	1	3	8	1	1	2				1		18
III	4	4	2	12	4	5		1	1	7	2	1	43
IV	1	3	9	12	3	2		1		1	6	2	40
Totals	6	8	18	33	8	11	2	2	1	8	10	4	111





## membership forum

*Membership Forum is intended to serve as a communicative tool for ISMS Membership.*

*The Editors encourage comment and criticism on issues of the day.*

*Correspondence should be addressed to: IMJ, 55 E. Monroe, Suite 3510, Chicago 60603.*

### Mental Health Code Debate

In response to Dr. Alex J. Spadoni's editorial in the February, 1977 *IMJ*, I would like to add my concerns about the final report of the Governor's Commission to Revise the Mental Health Code.

Like many physicians, I question the necessity for the extensive revision of the presently-used 1967 Code. I have worked successfully with the Code for seven years and feel that it already provides my patients with "equal protection of the laws, fair and humane treatment with the least possible restrictions on freedom." The proposed revisions seem based on changing legal opinions that have enveloped our country during the past decade—opinions that remain controversial. Yet, we are asked to adopt these opinions as though they were dogma and develop an entirely new mental health code designed not to benefit our patients but to place further restrictions on care, encourage conflict and mistrust between patient and physician, delay treatment of patients and increase health care costs. The Governor's Commission has consistently ignored the fact that we are not treating healthy people but individuals suffering from psychiatric disease.

The new code seems designed to turn our psychiatric wards into courtrooms with rights posted, rights read to patients, judges and lawyers in frequent attendance, letters of explanation sent to the Human Rights Authority and legal advocates, etc. Regulations with the force of law abound on every page and the physician's independent judgment is questioned repeatedly. The new

code would require the increased written justification of physician decisions; all of this paperwork takes time and will not result in improved patient care.

And isn't it important that our patients receive good care? Will the new Code mean that our patients will necessarily receive better care? Has it been shown in Illinois hospitals that our patients are being neglected, abused and mistreated? I write from the perspective as head of a psychiatric unit with 60 beds. Our patients receive excellent care and their rights are intact, not because of the Mental Health Code but because we are ethical professionals doing our jobs.

Inconsistencies within the proposed new code further confuse the situation. Section 3-208 notes that a physician must inform an involuntary patient "that he does not have to talk to the examiner," yet Section 3-602 states that the "certificate shall indicate the physician examined the respondent not more than 72 hours prior to admission." How can a physician examine a patient without the patient's talking?

In another example, Section 2-107 explicitly states "No generally accepted mental health service, including medicine, shall be given to a recipient of services unless he is given an opportunity to refuse such services." And then the following qualification appears in the next paragraph: "notwithstanding the right to refuse, generally accepted services may be given in order to prevent a recipient from causing serious physical harm to himself or others."

The Commission reflects the work of 36 members and 46 advisory members. Was there unanimity in this report? If not, as I suspect, why is there no minority report? I have many additional questions about other recommenda-

tions but feel helpless to effect any changes in the Commission's recommendations. The section on restraint and seclusion is impossible and impractical. I do not believe that we should keep two records for psychiatric patients, one for the psychiatrist's private notes and one for the patient's examination. I question whether 12-year-old children should be able to attend a clinic without parental permission and I do not believe that we should be told how to admit a patient to a hospital, (i.e., informal admission rather than voluntary consent).

My patients and I have a large stake in how I practice my profession. The new Code will complicate and interfere with my care. It will not make care more accessible to patients, but rather more difficult to obtain. In the Commission's efforts to legislate patient rights, they have produced a document which focuses less on people, but more on regulations.

Glen Pittman, M.D., Chairman  
Department of Psychiatry  
Memorial Medical Ctr., Springfield

### What Has Organized Medicine Done For Me?

This is a question heard over and over across the state, and particularly among young physicians contemplating the advisability of joining organized medicine. Literature concerning the availability of insurance programs, civic involvement, publications, and placement services has been disseminated to would-be members. These programs

have motivated many to join organized medicine, but the basic question still remains. What follows should answer a part of this question.

For house staff, the AMA Resident Physician Section (RPS) has labored for many goals, some of which include:

- house staff members on all AMA Councils except the Judicial Council. This places house staff in positions to have meaningful participation in the formulation of AMA policy.

- formulation of Guidelines for House Staff Contracts or Agreements. This included a position which declared that off-duty hours of house staff were not the business of the training institution. These hours could be utilized for additional employment provided this did not conflict with the resident's primary responsibility.

- formal opposition to the Goals and Priorities (GAP) Report of the National Board of Medical Examiners which recommended withholding licensure from physicians until completion of residency training.

- AMA endorsement of RPS resolution on physician's practice rights. This recognized the right and necessity to use legal means to protest when intolerable and unwarranted burdens are

placed upon their patients or themselves.

Recent federal draft legislation of the AMA recommended for introduction to the 95th Congress include:

- income tax exemption for certain scholarship benefits for recipients of medical scholarships. This would apply to the Armed Services Professions Scholarships programs and the PHS and NHSC scholarships.

- tax provisions that exempt from taxable income certain loan forgiveness for medical service in shortage areas.

- creation of a separate Department of Health in the Executive Branch of federal government, headed by a doctor of medicine. This would replace the present health functions of the present HEW structure. A Coordinating Commission designed to eliminate wasteful and duplicative programs is also proposed.

- proposed bonus pay for *all* physicians of uniformed services irrespective of the time they began service. This would include some adjustment for any previously incurred *federal* benefits prior to active duty, e.g. medical scholarships.

These are only a few of the recommended bills which could affect you.

Many other bills have been introduced to benefit the recipients of our labor, the consumer of health care.

These things don't happen by magic. They are the product of a lot of hard work by concerned people at *all levels* of national, state, county, and component specialty societies of organized medicine. Active involvement in these proceedings should be an integral part of every physician's commitment to the profession of medicine and the delivery of quality care to our patients. The time to begin involvement is in the training years of residency, and our local, state, and national associations have provisions for active participation by house staff at all levels. The future of medicine in this country will be in our hands in the very near future and we need to be prepared and informed to assume a responsible role. Think about it and come to the next meeting of the ISMS RPS, April 23, 1977. It will be held at the Holiday Inn Mart Plaza Hotel, Chicago, beginning at 8:30 A.M. Hope to see you there.

Sincerely,  
Paul M. Stromborg, M.D.  
President, Hines VA House Staff  
Delegate, Resident Physicians Section.

---

## Cut the Risk of a Malpractice Suit

### Make an ISMS Action Call

### 312/782-1722

The ISMS ACTION CALL telephone information system gives you access to a constantly expanding library of taped messages which can help you minimize your chances of being sued. The library also contains tapes which outline what to do if you are sued and how to counter frivolous litigation.

You can consult the ISMS ACTION CALL tape library between 9 a.m. and 4:30 p.m., Monday through Friday. Dial (312) 782-1722 and ask for the tape by number.

#### No. PREVENTION/DEFENSE

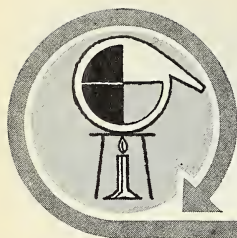
1. Communication Can Prevent Litigation
2. Medical Records . . . A Key to Your Defense
3. Good Prescribing Habits Can Keep You Out of Court
4. Obtaining Patient Consent That Will Stand Up in Court
5. Parental Consent in Treatment of Minors . . . When It's Needed

#### SUITS/INSURANCE

6. What Happens When You're Sued
7. Dangers of Dropping Malpractice Coverage

#### COUNTER MOVES

8. Filing a Countersuit
9. Recovering Defense Costs Through Section 41
10. Initiating Disciplinary Action Against Attorneys



# new pharmaceutical specialties

By PAUL DEHAEN

For detailed information regarding indications, dosage, contraindications and adverse reactions, refer to the manufacturer's package insert or brochure.

**New Single Drugs**—Drugs not previously known, including new salts.

**Duplicate Single Drugs**—Drugs marketed by more than one manufacturer.

**Combination Products**—Drugs consisting of two or more active ingredients.

**New Dosage Forms**—Of a previously introduced product.

The following new drugs have been marketed:

## NEW SINGLE DRUGS

**VIRA-A** Ophthalmic Antiviral Rx  
 Manufacturer: Parke-Davis  
 Nonproprietary Name: Vidarabine (Adenine arabinoside)  
 Indications: Acute keratoconjunctivitis  
 Superficial keratitis caused by Herpes simplex  
 Administration: One half-inch into the lower conjunctival sac every three hours.  
 Supplied: Ophthalmic ointment, 3%

## DUPLICATE SINGLE DRUGS

**FUNDUSCEIN** Diagnostic Rx  
 Manufacturer: SMP Div., Cooper Laboratories  
 Nonproprietary Name: Fluorescein sodium  
 Indications: Ophthalmic angiography, including examination of the fundus  
 Determination of circulation time  
 Dosage: Adults: 500 to 750 mg injected rapidly into the antecubital vein  
 Children: 3.5 to 5 mg per lb of body weight  
 Supplied: Ampules, 5 ml 10%  
 3 ml 25%

**PANOFEN Tablets** Analgesic o.t.c.  
 Manufacturer: Panray Div., Ormont Drug & Chemical Co.  
 Nonproprietary Name: Acetaminophen  
 Indications: Temporary relief of pain  
 Dosage: One to two tablets 3 or 4 times daily  
 Children one-half the adult dose  
 Supplied: Tablets, 325 mg

## PANOPHYLLINE FORTE

Manufacturer: Panray Div., Ormont Drug & Chemical Co.  
 Nonproprietary Name: Theophylline Sodium Glycinate  
 Indications: Acute bronchial asthma  
 Reversible bronchospasm associated with chronic bronchitis and emphysema  
 Dosage: Adults, 0.3 g every 6 hours  
 Children, 3 to 7 mg/kg every 6 hours  
 Supplied: Elixir, 15 ml, 330 mg  
 Alcohol 20%

## Bronchodilator Rx

## COMBINATION PRODUCTS

**DUOFILM** Dermatological Prep. Rx  
 Manufacturer: Stiefel Laboratories  
 Composition: Salicylic acid 16.7%  
 Lactic acid 16.7%  
 Indications: Keratolytic agent for the removal of benign warts  
 Contraindications: Diabetics with impaired blood circulation  
 Supplied: Ointment, bottles, 1/2 oz  
 Application: Soak affected area with hot water  
 Apply four drops to the wart

**LACTICARE Lotion** Dermatologic Preparation o.t.c.  
 Manufacturer: Stiefel Laboratories  
 Composition: Sodium pyrrolidone carboxylate 2.5%  
 Lactic acid 5%  
 Indications: Various forms of dry skin  
 Xerosis, asteatosis, pruritus senilis, atopic dermatitis  
 Application: Use sparingly and rub in gently 2 or 3 times daily  
 Supplied: Bottles, 8 fl. ozs

**SULFOXIL Lotion** Dermatological Preparation Rx  
 Manufacturer: Stiefel Laboratories  
 Composition: Benzoyl Peroxide, regular 5%  
 strong 10%  
 In lotion base with emollients  
 Indications: Topical aid in the treatment of acne  
 Application: Apply once daily for three successive days  
 Supplied: Plastic bottles, 1 oz



For lungs that need  
all the help you can give them  
in chronic bronchitis/emphysema  
**Bronkotabs<sup>®</sup>**

ephedrine/theophylline/glyceryl guaiacolate/phenobarbital



Potent bronchodilation and rapid reduction of bronchial edema open constricted airways for easier breathing.

Efficient expectorant action thins and loosens tenacious mucus to facilitate its removal.

Gentle sedation produces mild calming action.

*Helpful addition to an aggressive management program*

## **BRONKOTABS<sup>®</sup>**

Each tablet contains ephedrine sulfate 24 mg, glyceryl guaiacolate 100 mg, theophylline 100 mg, phenobarbital 8 mg (warning: may be habit-forming).

**PRECAUTIONS:** With Bronkotabs therapy sympathomimetic side effects are minimal. However, frequent or prolonged use may cause nervousness, restlessness, or sleeplessness. Bronkotabs should be used with caution in the presence of hypertension, heart disease, or hyperthyroidism. Drowsiness may occur. Ephedrine may cause urinary retention, especially in the presence of partial obstruction, as in prostatism.

**RECOMMENDED DOSAGE:** One tablet every 3 or 4 hours, not to exceed five times daily. Children over 6: one half adult dose.

**SUPPLIED:** Bottles of 100 and 1000 scored tablets.

**BREON**

BREON LABORATORIES INC. • 90 Park Avenue, New York, N.Y. 10016



# ISMS Guide to Continuing Medical Education

Compiled for Illinois physicians by the  
ILLINOIS COUNCIL ON CONTINUING MEDICAL EDUCATION  
55 E. Monroe St., Suite 3510 • Chicago, IL 60603 • (312) 236-6110



Items for this Calendar must be received 90 days prior to the event. Those received earlier may appear in up to three monthly issues.

**WARNING!** Items for this Calendar come from many sources, often far in advance of the publication date. Sometimes, cancellations or changes in date, place or time occur too late to be corrected before publication. You are urged to contact the sponsoring organization to confirm information given below.

## MAY

### Anesthesia

**SPECIALTY REVIEW COURSE IN ANESTHESIOLOGY**  
For: Anesthesiologists. Lecture, May 21, 9:00 am—One week. Cook County Graduate School of Medicine, Chicago. Speaker: Alon P. Wimmie, M.D. (Coordinator). CME Credit: 40 hrs. AMA Cat. 1. Fee: \$200. Reg. Limit: 300. Sponsor, contact: Cook County Graduate School of Medicine, 707 S. Wood St., Chicago, 60612. Attn: Robert J. Baker, M.D., Dean. Telephone: (312) 733-2800.

### REGIONAL ANESTHESIA & THERAPEUTIC NERVE BLOCKING

For: Anesthesiologists. Lecture, May 30, 9:00 am—One week. Cook County Graduate School of Medicine, Chicago. Speaker: Vincent J. Collins, M.D. (Coordinator). CME Credit: 40 hrs. AMA Cat. 1. Fee: \$300. Reg. Limit: 8. Sponsor, contact: Cook County Graduate School of Medicine, 707 S. Wood St., Chicago, 60612. Attn: Robert J. Baker, M.D., Dean. Telephone: (312) 733-2800.

### Cardiology

**CARDIOVASCULAR DISEASE WORKSHOP**  
For: General Practitioners and Family Practitioners. One and one-half day symposium, May 19, 9:00 AM-5:00 PM and May 20, 9:00 AM-12:30 PM. Ramada Inn Convention Center, Champaign. Speaker: Rolf Gunnar, M.D. CME Credit: 10 hrs. AMA Cat. 1. Fee: \$300. Sponsor, contact: Illinois Heart Association, 1181 N. Dirksen Parkway, P.O. Box 2666, Springfield, IL 62708. Attn: Sandra Boston. Telephone: (217) 525-1350. Co-sponsor: American Heart Association Council on Clinical Cardiology.

### Dermatology

**SPECIALTY REVIEW COURSE IN DERMATOLOGY**  
For: Dermatologists. Lecture, May 2, 9:00 am—One week. Cook County Graduate School of Medicine, Chicago. Speaker: Marshall Blankenship, M.D. (Coordinator). CME Credit: 35 hrs. AMA Cat. 1. Fee: \$200. Reg. Limit: 75. Sponsor, contact: Cook County Graduate School of Medicine, 707 S. Wood St., Chicago, 60612. Attn: Robert J. Baker, M.D., Dean. Telephone: (312) 733-2800.

### Emergency Medicine

**EMERGENCY MEDICAL SERVICES—ORGANIZATION AND ADMINISTRATION**  
For: Physicians, Hospital Administration, Physician Assistant, Paramedic, 3-day short course, May 4 and 5, 9:00 AM-5:00 PM, May 6, 9:00 am. Hyatt Regency O'Hare, Chicago. Speaker: Peter Rosen, M.D., U. Chicago Med. School. CME Credit: 18 hrs. American College of Emergency Physicians. Fee: \$250. \$220 before April 10. Reg. Deadline: April 30. Sponsor: University of Chicago Hospitals & Clinics. Contact: Technomic Publishing Co., Inc., 265 Post Road, P.O. Box 8, Saugatuck Station, Westport, CT 06880. Attn: John J. Dwyer, Vice-President. Telephone: (203) 226-6356. Co-sponsor: Technomic Publishing Co., Inc.

### Family Medicine, Gerontology

**HEALTH CARE AND HUMAN NEED IN SEX AND AGING**  
For: Physicians, Nurses, Therapists. 2 day workshop, May 13, 9:00 AM-8:45 PM and May 14, 9:00 AM-5:00 PM. Chicago. Speaker: Dr. Margaret Huyck. CME Credit: 16 hrs. AMA Category 2. Fee: \$75. Reg. Limit: 100. Reg. Deadline: May 1. Sponsor, contact: National Institute for Human Relations, 180 N. Michigan Ave., Chicago, IL 60601. Attn: Jessie Potter. Telephone: (312) 236-0051. Co-sponsor: University of Illinois School of Public Health.

### Family Medicine, Pediatrics, Internal Medicine

#### THE TREATMENT AND MANAGEMENT OF EPILEPSY IN CHILDREN AND ADOLESCENTS

For: Family Practice, General Practice, Pediatrics & Internal Medicine. One-day program, May 16. University of Illinois Medical Center Campus. Speaker: Dr. Philip Forman. Fee: \$35; \$15 (residents). Reg. Limit: 80. Reg. Deadline: May 2. Sponsor, contact: Dept. of Neurology, Abraham Lincoln Sch. of Med., U. of I. College of Medicine, Office of Continuing Education, 1853 W. Polk St., Room 144, Chicago, IL 60612. Attn: Sarah Brown. Telephone: (312) 956-8025.

### Family Therapy

**INTEGRATING THERAPEUTIC MODALITIES**  
For: Mental Health Practitioners and Physicians. One-day workshop, May 21, 9:30 AM-4:30 PM. Chicago. Illini Union, 838 S. Wolcott. Speaker: Norman Paul, M.D., and Betty Byfield Paul, A.C.S.W. CME Credit: 7 hrs. AMA Cat. 1. Fee: \$35. Sponsor, contact: The Family Institute of Chicago/Center for Family Studies, Ten East Huron, Chicago, IL 60611. Attn: Belinda Stone. Telephone: (312) 440-1414. Co-sponsor: Institute of Psychiatry, Northwestern Memorial Hospital and Northwestern University Medical School.

### Medicine

**STATE & NATIONAL BOARD REVIEW (CLINICAL)**  
For: Internists & Primarily for Family Practitioners. Lecture, May 2, 8:00 am—6 days. Cook County Graduate School of Medicine, Chicago. Speaker: Sheldon S. Waldstein, M.D. (Coordinator). CME Credit: 53 hrs. AMA Cat. 1. Fee: \$225. Reg. Limit: 150. Sponsor, contact: Cook County Graduate School of Medicine, 707 S. Wood St., Chicago, 60612. Attn: Robert J. Baker, M.D., Dean. Telephone: (312) 733-2800.

#### SPEC. REVIEW COURSE IN INTERNAL MEDICINE, CERTIFYING (PREP. FOR BOARD)

For: Internists. Lecture, May 1 and May 15, 1:00 pm—One week. Cook County Graduate School of Medicine, Chicago. Speaker: Sheldon S. Waldstein, M.D. (Coordinator). CME Credit: 64 hrs. AMA Cat. 1. Fee: \$250. Reg. Limit: 550. Sponsor, contact: Cook County Graduate School of Medicine, 707 S. Wood St., Chicago, 60612. Attn: Robert J. Baker, M.D., Dean. Telephone: (312) 733-2800.

### Musculoskeletal Trauma

**MUSCULOSKELETAL TRAUMA**  
For: All physicians. Clinical program on Trauma, May 12, 8:00-10:00 pm. John B. Murphy Auditorium, 50 East Erie St., Chicago. CME Credit: 2 hrs. AMA Cat. 1. AAFP Elective. Fee: None. Sponsor, contact: Chicago Committee on Trauma of the American College of Surgeons, 1211 N. Dearborn St., Chicago, IL 60610. Attn: Mrs. Lillian Hulse. Telephone: (312) 246-3788 or 482-8686. Co-sponsor: Rush-Presbyterian St. Luke's Hospital.

### OB-GYN

#### SPECIALTY REVIEW COURSE IN OBSTETRICS & GYNECOLOGY

For: Gynecologists and Obstetricians. Lecture, May 16, 9:00 am—two weeks. Cook County Graduate School of Medicine, Chicago. Speaker: John G. Masterson, M.D. (Coordinator). CME Credit: 83 hrs. AMA Cat. 1. Fee: \$375. Reg. Limit: 125. Sponsor, contact: Cook County Graduate School of Medicine, 707 S. Wood St., Chicago, 60612. Attn: Robert J. Baker, M.D., Dean. Telephone: (312) 733-2800.

### Pain Management

**CURRENT CONCEPTS IN PAIN MANAGEMENT**  
For: Physicians and Allied Health Professionals. Symposium, May 13-14 (8:00 am-5:45 pm). Ambassador West Hotel, Chicago. Speaker: Eugene J. Rogers, M.D., F.A.C.P. CME Credit: 16 hrs. AMA Cat. 1. Fee: \$100. Reg. Limit: 150. Reg. Deadline: March 15. Sponsor, contact: Chicago Medical School, Dept. Rehabilitation Medicine, 2020 W. Ogden Ave., Chicago, 60612. Attn: Eugene J. Rogers, M.D., F.A.C.P. Telephone: (312) 226-4100 ext. 350. Co-sponsor: Veterans Administration Hospital at N. Chicago.

### Psychiatry

**GROUP PSYCHOTHERAPY AND THE "NEW" PSYCHOTHERAPISTS**  
For: Mental health care professionals. Lecture, May 18, 1:00-4:00 pm. Riveredge Hospital, Forest Park. Speaker: Max Rosenbaum, Ph.D., Author of "Intensive Group Experiences". CME Credit: 3 hrs. AMA Cat. 1. Fee: \$10. Reg. Limit: 200. Reg. Deadline: Reservations 7/17/00 ext. 342. Sponsor, contact: Riveredge Hospital, 8311 West Roosevelt Road, Forest Park, IL 60130. Attn: John Pontarelli. Telephone: (312) 771-7000 ext. 305.

**QUEST FOR PURPOSE IN PSYCHIC RESEARCH**  
For: Psychiatrists. Distinguished lecture series, May 18, 8:00 pm. Passavant Hospital, Chicago. Speaker: Stanley R. Dean, M.D., Stanley R. Dean Fund for Cat. 1. Fee: None. Sponsor, contact: Institute of Research in Psychiatry, CME Credit: 1½ hrs. AMA Psychiatry, Northwestern University Medical School, 320 East Huron, Chicago, 60611. Attn: Jeanne Smith. Telephone: (312) 649-8058.

### Radiology

**REFRESHER COURSE IN RADIATION SCIENCE**  
For: Radiologists. Lecture, May 16, 8:00 am—7 days. Cook County Graduate School of Medicine, Chicago. Speaker: Theodore Fields, M.S. (Coordinator). CME Credit: 60 hrs. AMA Cat. 1. Fee: \$375. Reg. Limit: 75. Sponsor, contact: Cook County Graduate School of Medicine, 707 S. Wood St., Chicago, 60612. Attn: Robert J. Baker, M.D., Dean. Telephone: (312) 733-2800.

### Surgery

**ADVANCES IN SURGERY**  
For: Surgeons. Lecture, May 9, 8:00 am—one week. Cook County Graduate School of Medicine, Chicago. Speaker: Robert J. Baker, M.D. (Coordinator). CME Credit: 40 hrs. AMA Cat. 1. Fee: \$200. Reg. Limit: 60. Sponsor, contact: Cook County Graduate School of Medicine, 707 S. Wood St., Chicago, 60612. Attn: Robert J. Baker, M.D., Dean. Telephone: (312) 733-2800.

### Trauma

**21st ANNUAL POSTGRADUATE COURSE ON FRACTURES AND OTHER TRAUMA**  
For: Orthopaedic surgeons, general surgeons, general physicians. 3½ day event (annually), May 11-13, 7:30a-5:00pm and May 14, 7:30am-noon. Sheraton Chicago Hotel. Speaker: C. McCollister Evans, M.D., Rochester, NY. CME Credit: 28 hrs. AMA Category 1. AAFP Elective. Fee: \$165 (for residents, interns and allied health professions)—\$55.00 with letter from Chief of Service). Sponsor, contact: Chicago Committee on Trauma of the American College of Surgeons. Attn: Ralph T. Lidge, M.D., c/o American College of Surgeons, 55 E. Erie St., Chicago, IL 60611. Telephone: (312) 392-4320.

## Cardiology

## ADVANCED CARDIOLOGY

For: Cardiologists. Lecture, June 6 (one week), 8:30 am, Cook County Graduate School of Medicine, Chicago. Speaker: Kenneth Rosen, M.D. (Coordinator). Fee: \$200. CME Credit: 30 hrs. AMA Cat. 1. Reg. Limit: 35. Sponsor, contact: Cook County Graduate School of Medicine, 707 S. Wood St., Chicago, IL 60612. Attn: Robert Baker, M.D., Dean. Telephone: (312) 733-2800.

## Family Medicine

## NORTHERN MICHIGAN SUMMER CONFERENCE

For: Family Physicians, Internists, Pediatricians. 5-day workshop, June 20-24, Shanty Creek Lodge, Bellaire, Michigan. CME Credit: AAP Elective; AMA Cat. 1; AOA. Fee: To be determined. Sponsor, contact: Office of Continuing Education, Dept. of PGM/HPE, Towsley Center, Univ. of Mich., Medical Center, Ann Arbor, MI 48109. Attn: Bette Armbruster. Telephone: (313) 763-0081.

## Family Medicine, Gerontology

HEALTH CARE AND HUMAN NEED IN SEX AND AGING For: Physicians, Nurses, Therapists. 2-day workshop, June 3, 9:00 AM-5:45 PM and June 4, 9:00 AM-5:00 PM. Chicago. Speaker: Dr. Margaret Huyck. CME Credit: 16 hrs. AMA Category 2. Fee: \$75. Reg. Limit: 100. Reg. Deadline: May 1. Sponsor, contact: National Institute for Human Relations, 130 N. Michigan Ave., Chicago, IL 60601. Attn: Jessie Potter. Telephone: (312) 236-0051. Co-sponsor: University of Illinois School of Public Health.

## Family Therapy

## PERSONAL/PROFESSIONAL GROWTH WORKSHOP FOR THERAPISTS: WITH/WITHOUT PARTNERS

For: Physicians and Mental Health Practitioners. Three-day workshop, June 23, 7:30 PM-10:30 PM; June 24, 9:00 AM-9:00 PM; June 25, 9:00 AM-3:00 PM. Oak Park, IL. Speaker: Chuck Kramer and Jan Kramer. CME Credit: 20 hrs. AMA Cat. 1. Fee: \$200 (couple); \$125 (individual). Reg. Limit: 16. Sponsor, contact: The Family Institute of Chicago/Center for Family Studies, Ten East Huron, Chicago, IL 60611. Attn: Belinda Stone. Telephone: (312) 440-1414. Co-sponsor: Institute of Psychiatry, Northwestern Memorial Hospital and Northwestern University Medical School.

## Hematology

## BLOOD BANKING FOR MEDICAL TECHNOLOGISTS

For: Medical Technologists. 2-day workshop, June 2, 3, Towsley Center, MI. CME Credit: AAP Elective; AMA Cat. 1; CEU credits. Fee: To be determined. Sponsor, contact: Office of Continuing Education, Dept. of PGM/HPE, Towsley Center, Univ. of Michigan Medical Center, Ann Arbor, MI 48109. Attn: Bette Armbruster. Telephone: (313) 763-0081. Co-sponsor: MABB-MSMT.

## Pediatrics

## PEDIATRIC POSTGRADUATE COURSE

For: Pediatricians, Family Practitioners, Ped. & F.P. Residents. One day symposium, June 8, 9:00 AM-3:00 PM. Chicago. Speakers: Philip Dodge, M.D., Michael Cohen, M.D., Victor Chernick, M.D. CME Credit: To be determined. Fee: None. Sponsor: The Children's Memorial Hospital, Dept. of Pediatrics, Northwestern Univ.-McGaw Medical Center, Contact: Wayne Borges, M.D., Medical Director for Education, The Children's Memorial Hosp., 2300 Children's Plaza, Chicago, IL 60614. Telephone: (312) 649-4302.

## Pulmonary Disease

## PULMONARY DISEASE WORKSHOP

For: Family Physicians, Internists. 3-day workshop, June 8-10, Towsley Center, MI. CME Credit: AAP Prescribed; AMA Cat. 1. Fee: To be determined. Sponsor, contact: Office of Continuing Education, Dept. of PGM/HPE, Towsley Center, Univ. of Mich., Medical Center, Ann Arbor, MI 48109. Attn: Bette Armbruster. Telephone: (313) 763-0081. Co-sponsor: Michigan Academy of Family Physicians.

## Radiology

## RADIATION ONCOLOGY

For: Radiologists. Lecture, June 1 (3 1/2 days), 8:00am, Cook County Graduate School of Medicine, Chicago. Speaker: Walid A. Hinde, M.D. (Coordinator). CME Credit: 34 hrs. AMA Cat. 1. Fee: \$200. Reg. Limit: 75. Sponsor, contact: Cook County Graduate School of Medicine, 707 S. Wood St., Chicago, IL 60612. Attn: Robert J. Baker, M.D., Dean. Telephone: (312) 733-2800.

## Surgery

## MANAGEMENT OF COMPLICATIONS IN SURGERY

For: Surgeons. Lecture, June 6 (4 days), 8:00am, Cook County Graduate School of Medicine, Chicago. Speaker: Robert J. Baker, M.D. (Coordinator). CME Credit: 28 hrs. AMA Cat. 1. Fee: \$175. Reg. Limit: 55. Sponsor, contact: Cook County Graduate School of Medicine, 707 S. Wood St., Chicago, IL 60612. Attn: Robert J. Baker, M.D., Dean. Telephone: (312) 733-2800.

## Surgery

## SURGICAL MANAGEMENT OF PENETRATING NECK TRAUMA

For: Physicians, Surgeons. CME Lecture, June 11, 8:00 AM. Evanston, Speaker: John D. Saletta, M.D., Cook County Hospital. CME Credit: 1 hr. AMA Cat. 1. Fee: None. Sponsor, contact: St. Francis Hospital, 355 Ridge Ave., Evanston, IL. Attn: M. P. Byrne, M.D., Director of Medical Education. Telephone: (312) 492-6227.

## CME Planning Aids

ICCME continually develops a variety of "how-to" material for CME Planners—DME's, program chairmen of hospitals and medical societies (both specialty and geographic), and others. All items are FREE to Illinois physicians and CME sponsors.

To learn what's currently available, request the "CME Planning Aids Order Form"; write or call . . .

Illinois Council/CME  
55 E. Monroe St., Suite 3510  
Chicago, IL 60603  
(312) 236-6110

## JULY

## Family Therapy

## INTRODUCING FAMILY SYSTEMS (Introductory)

For: Physicians and Mental Health Practitioners. One-week course, July 11-15, 9:00 AM-3:30 PM Daily. Chicago. Speaker: Nancy Reed, ACSW. CME Credit: 35 hrs. AMA Cat. 1. Fee: \$130. Reg. Limit: 24. Sponsor, contact: The Family Institute of Chicago/Center for Family Studies, Ten East Huron, Chicago, IL 60611. Attn: Belinda Stone. Telephone: (312) 440-1414. Co-sponsors: Institute of Psychiatry, Northwestern Memorial Hospital and Northwestern University Medical School.

## Family Therapy

## ON BECOMING A FAMILY THERAPIST (Intermediate)

For: Physicians and Mental Health Practitioners. One-week course, July 18-22, 9:00 AM-3:30 PM Daily. Chicago. Speaker: Robert E. Rutledge, ACSW. CME Credit: 35 hrs. AMA Cat. 1. Fee: \$130. Reg. Limit: 24. Sponsor, contact: The Family Institute of Chicago/Center for Family Studies, Ten East Huron, Chicago, IL 60611. Attn: Belinda Stone. Telephone: (312) 440-1414. Co-sponsors: Institute of Psychiatry, Northwestern Memorial Hospital and Northwestern University Medical School.

## Family Therapy

## THE PRACTICING FAMILY THERAPIST (Advanced)

For: Physicians and Mental Health Practitioners. One-week course, July 25-29, 9:00 AM-3:30 PM Daily. Chicago. Speaker: Lynn Parker Wahl, ACSW. CME Credit: 35 hrs. AMA Cat. 1. Fee: \$130. Reg. Limit: 20. Sponsor, contact: The Family Institute of Chicago/Center for Family Studies, Ten East Huron, Chicago, IL 60611. Attn: Belinda Stone. Telephone: (312) 440-1414. Co-sponsors: Institute of Psychiatry, Northwestern Memorial Hospital and Northwestern University Medical School.

## Cancer—Educational Materials

A variety of reprints, motion pictures (8mm and 16mm), tapes, slides, and exhibits are available from the American Cancer Society's Illinois office. That agency also maintains a speakers bureau. Topics covered include both physiological and psychological aspects; material is available to meet the needs of physicians, nurses, and patients.

For full information, write to . . .

Illinois Division, Inc.  
American Cancer Society  
337 South Wabash Avenue  
Chicago, IL 60603

## Would an Outside View Help your Hospital CME?

The Illinois Hospital CME Consultation service can improve your in-hospital CME by helping you to build an up-to-date conception designed to enhance individual physicians' full clinical potential—and discard stereotyped group efforts to "keep up." The two-part process begins with self-analysis using a unique 16-page booklet—FREE to Illinois hospitals. The second part involves a personal visit and report by an expert on effective in-hospital CME; for the Consultant's visit, a modest charge is necessary to cover his honorarium, travel, and related costs.

For full information, ask for the "Consultation booklet"; write or call . . .

Illinois Council/CME  
55 E. Monroe St., Suite 3510  
Chicago, IL 60603  
(312) 236-6110

## Have You Seen the New Illinois Mandatory CME Law?

In November, 1975, the Illinois Legislature passed a law requiring continuing medical education for re-licensure. The law will be administered by the State Department of Registration and Education. FREE copies of the law are available; write or call . . .

Illinois Council/CME  
55 East Monroe St., Suite 3510  
Chicago, IL 60603  
(312) 236-6110



## report

Illinois Society  
American Association of Medical Assistants

### 21st Annual Meeting AAMA Illinois Society

Holiday Inn, Bradley, Il

April 28-May 1, 1977

## Grow With Knowledge and Friendship

"Grow with Knowledge and Friendship" is the theme of the 21st Annual Meeting of the Illinois Society, American Association of Medical Assistants. This three-day meeting will begin with a business session on April 29, 1977, Kankakee Holiday Inn. On April 30th, a two-day series of educational programs will be initiated. There is an installation banquet on Saturday evening, April 30th.

The speakers for April 30th include Walter S. Feldman, M.D., J.D., F.C.L.M., on "Dealing with the Difficult Patient." He will address methods of evaluating and dealing effectively with the chronically tardy, uncooperative, hostile, depressed or hypochondriacal patient. He will discuss how to understand non-verbal messages, psychodynamics and how to communicate better with such patients.

Joseph A. Koprowski, Attorney at Law, will cover various examples of medical assistants' legal dilemmas and how to avoid such situations when he discusses "Medical Assistant—A Professional with Inherent Risk."

Ben C. Happach, C.C.C.E., C.M.P.A., will speak on identifying office policy, billing and collecting, and communicating with patients regarding their bills. "Management of Patients' Accounts," will emphasize the importance of iden-

tifying and recognizing current problems related to medical collection and taking steps to correct those problems.

A former Illinois Society Advisor, Robert J. Kramer, M.D., F.A.C.S., will close the day with "You and the Federal Government." Dr. Kramer will provide an update of various government bills and acts which affect private practice. He promises to help us understand present government programs which directly affect the medical assistant and the physician-employer.

Jeanne D. Green, CMA-A, the President-Elect of the American Association of Medical Assistants, will speak at a farewell breakfast on Sunday morning.

Continuing Education Credit will be offered to those attending the educational session scheduled for Saturday.

All AAMA members are invited to attend this meeting. Further information may be obtained thru the Registration Chairman, Mrs. Carol Zens, 552 S. Walnut, Chebanse, Illinois 60922. For information regarding membership in Illinois Society please contact First Vice President, Mrs. Velma Hukill, 115 N. Fourth Street, Cuba, Illinois 61427, or Second Vice President, Mrs. Jean Nelson, 829 Carnaby Court, Schaumburg, Illinois 60172.

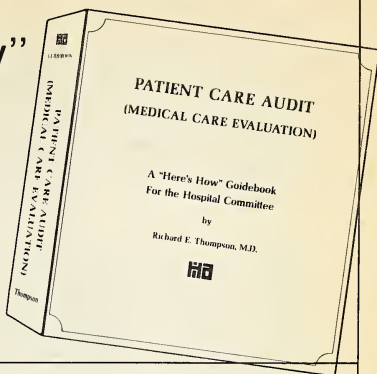


# Audit/MCE: A "Here's How" Guidebook For The Hospital Committee

by RICHARD E. THOMPSON, M.D.



ILLINOIS HOSPITAL ASSOCIATION  
1200 JORIE BOULEVARD • OAK BROOK, ILLINOIS 60521



This unique and practical new resource for Hospital Audit Committees is written by a physician who spent 12 years in clinical practice prior to becoming a respected authority on Patient Care Audit.

Using plain clinical language and examples suggested by actual audit committee experiences, the *Guidebook* demonstrates completion of audit studies from topic selection through action and reporting steps. Included are:

- How to design the Audit/MCE Study.
- How to select valid quality care indicators (criteria).
- How to properly handle variations from the criteria.
- How to Analyze Audit-disclosed Problems.
- How to pick the right action steps.

- How to use "Pre-Meeting preparation" for each step to make audit committee meetings shorter.
- How to CHECK each step in the audit study as it is performed to avoid frustrating bottlenecks, assure more meaningful results, and prepare your audit studies to withstand scrutiny by external agencies.
- How to answer 16 "Questions Clinicians Ask" about Patient Care Audit.
- How to interpret and use audit findings in new, more meaningful ways.
- How to report audit results to others, such as the Hospital's Board of Trustees.

Others have improved the meaningfulness and acceptance of their Patient Care Audit programs through the use of techniques demonstrated in the *Guidebook*. SO CAN YOU!

TO ORDER, FILL IN AND MAIL THIS FORM



ILLINOIS HOSPITAL ASSOCIATION / 1200 JORIE BOULEVARD, OAK BROOK, ILLINOIS 60521

Please send ☐ copies of "Audit/MCE: A Guidebook for the Hospital Committee," by Richard E. Thompson, M.D.

NAME

TITLE

ORGANIZATION

ADDRESS

CITY  STATE  ZIP

☐ Bill me.

☐ Payment enclosed \$

☐ Bill my organization, P.O. #

Prices:

1-5 copies, remit \$19.95 per copy

6 or more, remit \$15.95 per copy



# Physician Recruitment Program

*In an effort to reduce the number of towns in Illinois needing physicians, the Physician Recruitment Program and the Doctor's Job Fair, are publishing synopses in the Journal.*

*Physicians who are seeking a place to practice or who know of any out-of-state physicians seeking an Illinois residence are asked to notify the Program.*

*Any areas wishing to be listed should contact: Mrs. E. Duffy, Physician Recruitment Program, ISMS, 35 E. Monroe, Suite 3510, Chicago, 60603.*

**CAIRO:** Community Hospital with 20,000 population, staff of 1 Dentist, 1 Pediatrician, 1 OB/GYN, 2 General Surgeons, 1 Internist seeking ambitious General Practitioner for rural community. Recreation, (boating, fishing on lakes, rivers; golf, tennis), education, (public, private and parochial). Financial assistance in moving, office space, staff. Excellent potential. Contact: Harvey Pettry, PADCO Community Hospital, Cairo, 62914. 618-734-2400. (5)

**CANTON:** Clinic established in 1937 serving the Spoon River Valley area. This multi-specialty clinic is located in a clinic building constructed in 1969, located two blocks from 250-bed hospital. Twelve physician group. 30 miles from Peoria School of Medicine. Contact: Harlan Crouch, 175 S. Main, Canton, 61520. 309-647-0201. (8)

**CARBONDALE:** Family Physician: Innovative neighborhood center in Southern Illinois seeks family practice physician to provide patient care and supervise other professionals and paraprofessionals in a clinic setting. Salary negotiable. Position available March, 1977. Contact: Robert Stalls, Director of Human Resources, City of Carbondale, 609 E. College, Carbondale, (618-549-5302). (6)

**CARTHAGE:** County Seat for Hancock County (Population 24,000). Need for Internist, Family Practice, and ER Physicians willing to conduct family practice. Memorial Hospital will guarantee first year income and provide office space. Four physicians and two surgeons at present. Contact: Harold A. Dietz, Administrator, Memorial Hospital, Carthage, 62321. 217-357-3131. (5)

**CHADWICK:** Rural area in northwestern corner of Illinois. Population 600. Strong farming community. Need general practitioner to set up solo practice. Office facilities available. Contact: Harold Frank, Box 38, Chadwick, 61014. (815) 684-5154 or 684-5147. (5)

**CHICAGO:** Progressive Community Hospital with active Emergency Department seeking an Orthopedic Surgeon. Good facilities available. Financial package attractive. Contact: Joel V. Bailey, 326 West 64th Street, Chicago 60621—312-962-4100. (8)

**CHICAGO HEIGHTS:** 35 man multispecialty group needs Board certified or eligible family practitioner. Located in 100,000 sq. ft. building. Ancillary services available include X-ray, lab, cardiology stress testing, physical therapy, speech therapy, biofeedback, optical shop, pharmacy. Plans for further expansion with investment opportunities. Call Mr. H. Cloys, 333 Dixie Hwy., Chicago Heights, 60411. 312-756-7447. (5)

**FAIRBURY:** population 3,500; fully accredited modern hospital in progressive rural community located 100 miles southwest of Chicago servicing 15,000. Housing, office, and financial assistance available. Only five general practitioners and one board eligible surgeon serving area. Contact Donald Patterson, Administrator, Fairbury Hospital, 519 South Fifth Street, Fairbury, 61739, (815) 692-2346. (8)

**FORT MADISON, IOWA:** Openings for 2 FP/GP, OB, PED., Int. in growing industrial city of 16,000 serving 70,000 on Miss. River. Solo, partnership, clinic available. Substantial salary, other incentives. U. of Ia. near, Excellent living area, 125 bed accredited hospital. Contact: Donald A. Buckert, Sacred Heart Hospital, Fort Madison, Ia. 52627. 319-372-6530. (5)

**HERRIN:** Trade area of 40,000. Sportsman's paradise of Southern Illinois. 20 minutes from S.I.U. and Medical School. Internal Medicine and Family Practice needed now. Partnerships and solo available. Modern office facilities. Financial assistance. Contact: Larry Feil, Herrin Hospital, Herrin, 62948. (618) 942-4710. (5)

**HOMER:** Family Practitioner—Eleventh ranking county in U.S. gross farm income; 20 min. to large town with two hospitals; drawing area 12,000; house and office building offered; town may help with equipment. Contact: Douglas Driscoll, RR2, Homer, 61849. (217) 896-2434. (5)

**ILLIOPOLIS:** Needed Family Physician for small community. Surrounding area about 6,000 population. Industrial practice possible. Twenty miles from five major hospitals, on Interstate. Financial assistance available. Will work with you on office facilities. Contact: John Burke, R.R. 1, Illiopolis, 62539. Daytime—(217) 753-4861; night—(217) 486-6009—collect. (5)

**JACKSONVILLE:** Two-college town of 26,000 needs Primary Care Physicians. Excellent opportunity for F.P.s and Internists to join young, 37-member staff, expanding hospital, and progressive medical climate where patient care is the bottom line. Med. school 35 min's with good teaching opportunities. Contact: Larry Bear, Passavant Hospital, Jacksonville, 62651. (217) 245-9541. (5)

**KANKAKEE:** Physician needed for area-wide trauma center in a 300 bed hospital. Emergency Medical training or training in primary care medicine is required. Salary commensurate with training and experience. Please contact Dr. R. Schuller at 500 West Court Street., Kankakee, Illinois 60901 or phone 815-937-2410. (6)

**LA SALLE-PERU:** Area population 35,000. Opportunities in hospital for family practice, internal medicine, pediatrics, OB-GYN. Twenty-five physicians at present with several over age 55. Two hours from Chicago. Office facilities. Financial assistance available. Numerous recreational facilities, good schools and housing. Contact: W. Schweickert, 925 West Street, Peru, 61354. (815) 223-3300. (5)

**LITCHFIELD:** Emergency Physician Opening—Join two full-time physicians staffing a Trauma Center in new hospital. Excellent salary, flexible scheduling to allow ample time for hobbies and leisure. Comfortable community of 8,000 with beautiful 1700 acre lake bordered by wooded homesites. Community interests include boating, fishing, hunting, farming, houses, golf, tennis, private flying and amateur theatre. One hour's drive to St. Louis or Springfield. Contact: Lee Johnson, M.D. or Jim Bohl at (217) 324-2191, St. Francis Hospital, Litchfield, 62056. (5)

**MENDOTA:** (City population 8000—service area 20,000). New medical clinic building next to hospital. Small town living with social and educational benefits of Chicago and other metropolitan areas close at hand. Financial assistance available. Busy practice available. Contact: E. E. Williams, Memorial Dr. & Rt. 51, Mendota, 61342. (815) 539-7461. (5)

**MORRIS:** Orthopedist and family practitioner urgently needed. Excellent opportunities for both in this rapidly growing rural community on Interstate 80 one hour from Chicago. Accredited 75-bed general hospital with new services and equipment planned. Service area 25,000-30,000. Contact: L. Wilhelm, M.D., P.O. Box 729, Morris, 60450. (815) 942-5474. (5)

**NEW ATHENS:** Population 2,200 (area population 17,000), 35 miles from St. Louis, Mo. Need one or two family physicians for new medical building. "Big city" attractions; best of shopping, recreation, and educational opportunities nearby. 1100 hospital beds within 20 minutes. Contact: Earl Becker, New Athens, 62264 or call collect (618) 475-2602. (5)

**OREGON:** Population 3800. Northern Illinois' most beautiful little town needs physician. On Rock River, two State Parks, 16 local industries. New Doctor with 3-year old practice would welcome associate. Great opportunity. Contact: Jean Davis, Etnyre Terrace, Oregon, 61061. Tel. 815-732-6248. (8)

**PEKIN:** Population 32,000. Hospital service area +50,000. Affiliated with Peoria School Medicine. 230-bed J.C.A.H. approved; well-equipped. Personal and capital financial assistance available. Ten miles to Peoria. Emergency services under contract. Opportunities for partnerships available. Contact: T. Larson or R. Tucker, M.D., Pekin Memorial Hospital, Pekin, 61554. (309) 347-1151. (5)

**PEORIA:** Emergency Medicine Residency Program seeks faculty for positions beginning immediately and July 1, 1977. 850 bed university affiliated hospital located in Central Illinois. Regional Trauma Center with 45,000 undifferentiated ER patient visits annually.

Positions combine academic and clinical responsibilities in developing residency program. Inquiries limited to certified/eligible primary care specialists (Internal Medicine, Pediatrics, Surgery) or graduates of ER residencies. Salary competitive with numerous fringes including malpractice. Send replies to Mr. Ronald Pechan, Assistant Administrator, St. Francis Hospital-Medical Center, 530 N.E. Glen Oak, Peoria, 61637. (309/672-2298). (8)

**PRINCETON:** New physicians offices under construction at Perry Memorial Hospital which serves Bureau County, population 40,000. Two hours southwest of Chicago. All recreational facilities available, good schools and comfortable living in country style. Contact John Revell, 606 South Main Street, Princeton, 61356. AC/815-875-4444. (6)

**ROCK ISLAND:** Excellent opportunity for family practitioners at new medical center physician's office building, rent free the first year. A substantial income guarantee and financial assistance are available. Contact: Thomas J. Lavery, Dir. Physician Recruitment, Rock Island Franciscan Hospital, 2701-17th Street, Rock Island, 61201. (309) 793-1000 (call collect). (5)

**RUSHVILLE:** Sixty miles west of Springfield. Progressive, growing community with 80 bed hospital serving population 12,000 to 15,000. Excellent schools, churches, shopping, recreation including a lake, golf course, pool, hunting and fishing. Office space with active physician, or private practice. Financial assistance. Contact: Charles Berry Jr., Administrator, Culbertson Hospital, Rushville, 62681. (217) 322-4321. (5)

**SILVIS:** Primary Care Physicians (Family Practice, Internal Medicine, Pediatrics) wanted to locate in new medical building adjacent to suburban hospital in Illinois Quad-Cities. Guarantee offered. For additional details write or call Noel Lee, M.D., 4430-34th Avenue, Moline, 61265. (309) 797-5811. (5)

**SPRINGFIELD:** Currently seeking family practitioners, internists, and an otolaryngologist to establish practice in new Community Medical Plaza. We offer many benefits and assistance to help physicians get started. If interested, call collect: (217) 529-7151 or write to: Diana Smalley, 5230 South 6th Street-Frontage Road, Springfield, Illinois 62703. (5)

**STERLING/ROCK FALLS:** Population 28,000. Immediate need for Cardiologist (non-invasive) and E.N.T. Has progressive 167 bed JCAH hospital serving 80,000 people with unlimited growth potential, all in a pleasant community with excellent recreational facilities. Contact: Dallas K. Larson, Administrator, Community General Hospital, Sterling, 61081. (815) 625-0400. (5)

**WHITEHALL:** Area population 12,000. Urgent need for family practice or general practice. Excellent educational, cultural and recreational environment. Licensed 30 bed hospital. Office, housing, and financial assistance available. Excellent opportunity for man or woman. George A. Stahl, 407 No. Main, White Hall, 62092. (217) 374-2444. (5)

# CLASSIFIED ADVERTISING

## POSITIONS & PRACTICE OPPORTUNITIES

**OB-GYN, ENT, PEDIATRICS, SPECIALISTS** needed by 16-man multispecialty clinic in university community of 50,000 in western Wisconsin; excellent retirement and fringe benefits; fine recreational opportunities; salary negotiable. Send curriculum vitae and references to: John R. Ujda, M.D., La Crosse Clinic, 212 South 11th Street, La Crosse, Wisconsin 54601.

**EMERGENCY PHYSICIANS**—Full or part time positions available with Metro Chicago Group. Major university hospital. University appointment, teaching responsibility in residency & MICU programs, liability insurance & generous compensation. Complete facilities include telemetry & specialty back-up. Postgraduate training or board cert. preferred. Send CV or call 8. J. Feldman, M.D., 250 E. Superior St., Chicago, Ill. 60611. (312) 649-2259.

**INTERNSHIP** interested in new health care systems, preventive medicine, health education, patient care, Chief of Clinical Medicine. Position open July, 1977. Affirmative Action/Equal Opportunity Employer. L. W. Akers, M.D., Director, University Health Service, Northern Illinois University, DeKalb, Illinois 60115.

**PRIMARY CARE PHYSICIAN** for large university health service. Excellent facilities, good geographic location, good fringes. Illinois License required. Affirmative Action/Equal Opportunity Employer. Position open July, 1977. L. W. Akers, M.D., Director, University Health Service, Northern Illinois University, DeKalb, Illinois 60115.

**NEONATOLOGIST** to join 10 member Pediatrics Division of a 100 doctor multispecialty clinic with adjacent hospital; located in Big 10 University community of 100,000; large referral practice, as well as primary care; new medical school offers opportunity for teaching; hospital has just under 1000 deliveries per year with 13,000 per year in area without designated center; OB/Pediatrics Departments are requesting state designation as perinatal center with completion in early 1977 of excellent new hospital, L & B, NICU facilities. Contact Medical Director, Carle Clinic, Urbana, IL 61801.

**PHYSICIAN FOR ACUTE ILLNESS DEPARTMENT** and Emergency Room. Become part of an expanding, dynamic multispecialty clinic in mid-western university community. Excellent salary, benefits. Write or call Medical Director, Carle Clinic, Urbana, IL 61801, (217) 337-3239.

**PHYSICIANS WANTED:** Full or part-time positions for psychiatrists or general practitioners available at the Alton Mental Health Center, Alton, Illinois (20 minutes from St. Louis). Salaries according to training and experience up to \$39,048. Illinois license required. Hospital accredited by JCAH. Contact E. Komlos, M.D., Medical Director, Alton Mental Health Center, 4500 College Avenue, Alton, Illinois 62002.

**FULL TIME PHYSICIAN** for Industrial Clinic in Skokie. Surgical experience needed. Salary negotiable. Must have Illinois license. Call (312) 674-4800, Mrs. McCubbin.

**ORTHOPEDIC SURGEONS**—Large multispecialty in Western Chicago area (DuPage County) seeks additional orthopedic surgeon's for busy community orthopedic practice. Attractive guaranteed salary plus incentive and complete fringe benefits package. Call Mr. Dave Bauer, III, Administrator, Glen Ellyn Clinic, S.C. (312) 469-9200. Ext. 305.

**EMERGENCY PHYSICIAN, McHENRY, ILLINOIS:** Position beginning July 1 for full-time, career-oriented emergency physician in 5-man group covering 10-bed 20,000 visit/yr. ER of 140-bed trauma center and mobile intensive care resource hospital 50 miles northwest of Chicago, near Wisconsin border. Excellent guarantee and fringes. Good work schedule. Go back to 20-man multispecialty clinic in adjacent building and from independent specialists in community. Small town (pop. 8,000). Ski and water sports area. Send curriculum vitae to: John Bowman, M.D., Director of Emergency Services, McHenry Hospital, 3516 W. Waukegan Road, McHenry, Illinois 60050.

**EXCELLENT OPPORTUNITY AND ENVIRONMENT**—Physician needed to practice general medicine in large outpatient clinic and 38-bed fully accredited hospital. Attends outpatient, college, college-age population. Salary negotiable, excellent fringe benefits. Contact L. W. Combs, M.D., Purdue Student Hospital, West Lafayette, Indiana 47907, (317) 749-2441. Equal access/equal opportunity employer.

**PRIMARY CARE PHYSICIAN** for large university health service. Nine or 12 months annual contract. Start July or August. Fine facilities, excellent university community, good geographic area. Illinois license required. We are an AA/EO Employer. Contact Loren W. Akers, M.D., Director, University Health Service, DeKalb, IL 60115.

**INTERNIST** for large university health service willing to give both specialty and primary care. May also be assigned certain supervisory and administrative duties if interested. Illinois license required. We are an AA/EO Employer. Contact Loren W. Akers, M.D., Director, University Health Service, DeKalb, IL 60115.

**EMERGENCY PHYSICIAN:** Off duty 3 weeks out of 5 weeks. Corporate group of 6, non-hospital employees, double physician coverage during peak loads, 40,000 visits yearly in autonomous emergency department. Salary \$52,000 plus \$23,000 in untaxed fringe benefits, including premiums for malpractice, disability, family health & accident, \$50,000 life insurance policies, professional society dues, profit sharing & pension plan funds. Central Illinois college town, 100,000 population. Primarily interested in U.S. trained, career emergency medicine physician. Apply by submitting curriculum vitae to: Box No. 883, c/o IMJ, 55 E. Monroe, Suite 3510, Chicago, IL 60603.

**UROLOGIST WANTED:** For rural downstate Illinois. Should be familiar with the Protestant work ethic concept. Guarantee of \$50,000. Reply to Box 884, c/o IMJ, 55 E. Monroe, Suite 3510, Chicago, IL 60603.

**STREATOR:** Orthopedic surgeon, second pediatrician, family practitioner, and internist needed to join multispecialty 13 physician group in midwest community. New clinic building directly across from hospital emergency room of 240 bed hospital. Salaries are open to negotiation. Partnership in one year, cross coverage. Benefits are numerous with profit sharing plan in operation. Contact C. T. Hawkins, M.D., Streator Medical Clinic, S.C., Streator, Illinois 61364. (815) 672-0511.

**RADIOLOGIST,** boarded to assume duties as chief radiologist for large multi-specialty clinic in western suburbs. Call Dave Bauer III 469-9200.

## FOR SALE, LEASE OR RENT

**MEDICAL CENTER FOR RENT,** Complete and ready to open. 4300 sq. ft., at 2301 E. 95th Street, Chicago. Lge. waiting rm., 18 exam. rms., X-ray rm., central a/c & heat. Call Gary Solomon, 334-5400.

**MEDICAL CLINIC,** for sale or lease, fully furnished and equipped including: 2 offices; X-ray; and reception area. Recently remodeled. Practice located in stable south side area of Chicago. Very accessible to Holy Cross Hospital. Area in need of doctor, practice should yield in excess of \$50,000 annually. Please call 991-1940 or 476-5786 evenings.

**RETIRING** general practitioner desires to sell lucrative practice located at 7848 South Homan Avenue, Chicago, Illinois. Immediately available. Office lease is transferable; seller will finance. Box 886, c/o IMJ, 55 E. Monroe, Suite 3510, Chicago, IL 60603.

**COMPLETE X-RAY AND FLUOROSCOPY UNIT (Mattern)** & darkroom equipment, examining and pediatric tables, scales, receptacles, aneroïd spghys, microthermadiathermy and ultrasonic units, diagnostic sets, speculae, jars & other instruments, intercom system, complete furnishings of medical offices. Also, private office and reception room furniture from Practitioner leaving practice. Please call 334-4700 between 11-4.

**CLINIC TO BE AVAILABLE** in Belvidere, Illinois, (Nice area for raising family) in August-September, 1977. Clinic is suitable for two or three doctors. Has 2450 square feet and is conveniently located in a small shopping area. The clinic owners will be able to assist interested doctors, financially, in establishing a practice. Write or Call collect (815) 398-0911, evenings (815) 543-6597, 1806 South Alpine Road, Rockford, Illinois. Richard R. Conner.



Blue Cross®  
Blue Shield®



# REPORT

## FOR *Illinois Physicians*

### Use of Telephone and Mail Hotline Services

Now in their second year of operation, the Telephone and Mail Hotlines of Health Care Service Corporation are proving their value as special services to physicians and their office personnel. They were established by the Plan as a convenience to professionals and their medical assistants.

Approximately 400 calls are received and processed daily over the telephone hotlines, 85% involving requests for information on Blue Shield benefits and the status of claims. Over 75% of the requests for information are completed in the course of a call.

When further information is required, communication counselors follow an inquiry referral procedure, entering the data on a referral form. It is then screened and routed to the appropriate areas of the Plan for a response. All such referrals indicate that they originated from a hotline inquiry. Responses are returned to the hotline supervisor where call-backs are made to the physician's office. When a response is delayed or a number cannot be reached, correspondence is sent to the doctor's office to complete the referred inquiry by post card or letter.

Seven communication counselors and a supervisor monitor the telephone hotline from 8:30 A.M. to 4:30 P.M. daily. Three lines on the WATS area system are reserved for downstate physicians and five lines are available for services in the Chicago Metropolitan Area.

- The toll-free number outside Chicago is (800) 972-8088.
- The Chicago number is 661-8088.
- The Medicare Part B Physicians Unit (for Cook County) is 661-8300.

The telephone hotline is a direct channel of communication on coverage and claim problems to our Plan for professionals. *The number should not be given to patients.*

The staff of counselors and supervisors are experienced in handling a wide variety of inquiries and requests in addition to data furnished on benefits and claims. Information is provided on claim filing procedures, completion of Blue Shield Physician Service Report forms, Major Medical and Dental programs, coverage for major groups and the



An average of 400 calls are received daily on the telephone hotline from professionals in the Chicago area and downstate. Seven counselors service the calls.

special coverage programs such as Pre-Admission Testing and Coordinated Health Care.

When a call is received regarding a claim, the counselor uses a direct access terminal at her desk to query the computer by keying-in the group and subscriber number of the patient. Data is then transmitted from the computer system to the counselor's DA screen, showing the status of the claim in question as approved, denied or delayed.

The Mail Hotline operates in the same corporate area as the Telephone Hotline, with several correspondents assigned to process the 4-part Professional Hotline Action Requests forms. Approximately 70 forms are received daily. This special form is designed to be used for Blue Shield inquiries, including questions relating to specific claims. The forms may be requested by mail or by calling the telephone hotline number. They should not be used for Medicare.



## ASK BLUE SHIELD ... ABOUT MEDICARE

### Physician's Imprinted Label Improves Claim Processing Time

A physician's imprinted label on the SSA-1490 Request for Medicare Payment form gives the Part B Medicare carrier accurate information on the provider's identification—an item essential to faster claim processing and payments.

When you need imprinted labels they may be obtained by using a special mailing address and box number established by Blue Shield for Cook County. These requests should be addressed to:

Medicare Part B  
Blue Cross-Blue Shield  
Post Office Box 2218  
Chicago, Illinois 60690  
Attention: Provider Update Unit

Newly licensed physicians without an identification code number should complete an SSA-1490 form and Item 8, with name, address, state license number, Social Security number and specialty, if any and send it to the above address.

A physician identification code number will be assigned by Blue Shield.

The imprinted label on the SSA-1490 form does not require the physician to accept assignment. To accept assignment, the assignment statement on the form must be checked and signed by the physician. Physicians who do not want to accept assignment are encouraged to complete and sign the 1490 for the beneficiary and to use their physician label to speed processing.

When you submit an SSA-1490 form without an imprinted label, please complete Item 8, including your first name, last name, middle initial, address, zip code, telephone number and physician identification code number.

---

### Diagnosis Needed on Medicare Claims

A diagnosis is necessary for the Part B Medicare carrier to relate the services provided to the treatment of the illness or injury. It is also helpful if the diagnosis is included on the physician's statement to the patient when billing the patient directly. The diagnosis avoids the necessity for the Medicare carrier to contact the physician for the information when the patient files for benefits and neglects to properly complete Item 4 on the SSA-1490 Request for Medicare Payment form.

### Changes in Laboratory Certification

Notice was received from the Bureau of Health Insurance, Social Security Administration of the following changes in the certification or participation or laboratories in the Medicare program.

The following laboratories have been approved for participation:

Diagnostic Scanning Laboratory  
6740 West Dempster  
Morton Grove, Ill. 60053  
Provider Number: 14-8324  
Effective Date: December 22, 1976

Forest Hill Medical Center Laboratory  
9050 West 81st Street  
Justice, Ill. 60453  
Provider Number: 14-8323  
Effective Date: January 1, 1977

Pittsfield Medical Laboratory  
55 East Washington Street  
Chicago, Ill. 60602  
Provider Number: 14-8322  
Effective Date: February 1, 1977

Lius Medical Laboratory  
1429 West Irving Park Road  
Chicago, Ill. 60613  
Provider Number: 14-8320  
Effective Date: August 8, 1976

#### No longer eligible for participation:

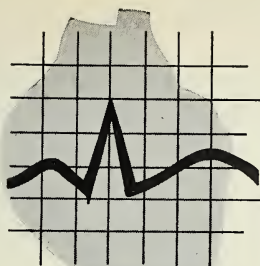
Mason-Barron Laboratories, Inc.  
15643 Lincoln  
Harvey, Ill. 60426  
Provider Number: 14-8303  
Effective Date: May 1, 1977

This facility of Mason-Barron Laboratories no longer participates:

Mason-Barron Laboratories, Inc.  
Palos Heights, Ill.  
Provider Number: 14-8296  
Effective Date: February 11, 1977

#### Request to withdraw approved:

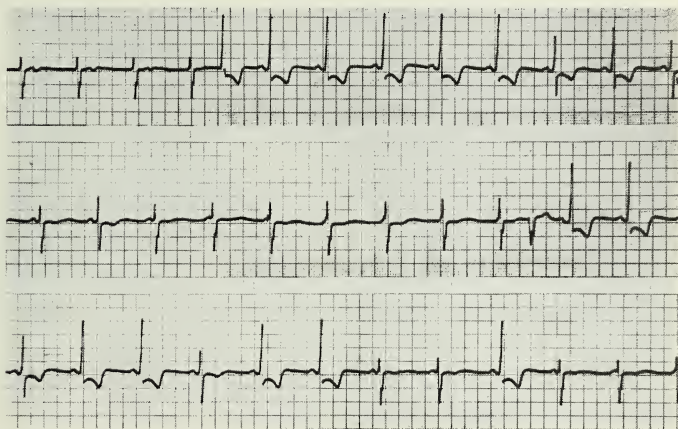
Azteca Laboratories  
3155 North Greenview  
Chicago, Ill. 60657  
Provider Number: 14-8265  
Effective Date: May 1, 1977



## ekg of the month

JOHN R. TOBIN, JR., M.S., M.D., RIMGAUDAS NEMICKAS, M.D.,  
PATRICK J. SCANLON, M.D., JOHN F. MORAN, M.S., M.D.,  
SARAH JOHNSON, M.D., and ROLF M. GUNNAR, M.S., M.D./  
Section of Cardiology, Department of Medicine,  
Loyola University Stritch School of Medicine

This patient is a 60-year-old man who had exertional chest pain that radiated to the left side of his neck for a year and a half. The pain was always relieved by sublingual nitroglycerin and was related to his activity. The pattern of the pain then began to change. It increased from once or twice a day to eight or ten times a day. It seemed to come with less activity than formerly and occasionally required two nitroglycerin tablets for relief. With this history of accelerating or unstable angina, the patient saw his physician and was hospitalized in the coronary care unit. In the evening of the first day in the coronary care unit, the rhythm strip shown below was recorded.



### Questions:

#### 1. The ECG rhythm strip shows:

- A. Non-diagnostic or non-specific ST-T wave changes compatible with ischemia.
- B. Atrioventricular dissociation.
- C. Junctional rhythm.
- D. Fusion beats.
- E. All of the above.

#### 2. Treatment of this arrhythmia would include:

- A. 100 mg lidocaine bolus with 1-2 mg lidocaine drip intravenously to follow the bolus.
- B. Prompt intravenous digoxin.
- C. Demand pacemaker placement.
- D. Watchful expectation.
- E. None of the above.

(Answers on page 389)

# we speak a language doctors understand

**Results! That's what group practices and medical labs are after when they make a decision about data processing systems.**

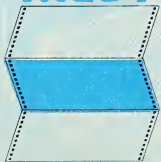
**Results are what Medical Data Systems® provides our users. Consider the results one clinic has realized in five years with MDS.**

- 1) 14% Reduction in over 120 day balances as a percent of accounts receivable.**
- 2) 5% Reduction in accounts receivable as a percent of gross billings.**
- 3) 14% Reduction in employees even though patient visits have increased 24% and billings are up 59%.**

**MDS is tailored to meet the needs of individual clients with specially designed programs for various size groups or labs.**

For More Information  
Contact Ken Williams, Vice President/Marketing

## MEDICAL DATA SYSTEMS®



**S-Tek  
COMPUTER SERVICES, INC.**

P.O. BOX 328 TERRE HAUTE, IN 47808 812-232-1385



# NEW ENSURE® PLUS

## High Calorie Liquid Nutrition.

## More Nutrition in Less Volume.



Certain clinical conditions, major burns, severe trauma and multiple fractures, for example, frequently impose calorie and nutrient demands that are often difficult to satisfy with standard one-Calorie-per-ml liquid feedings. ENSURE PLUS High Calorie Liquid Nutrition is intended for use when extra calories and higher concentrations of protein and other nutrients are needed to achieve a required calorie intake in a limited volume.

- **1500 Calories per liter**  
caloric density is 50% greater than available with most liquid feedings... reduces volume of intake necessary to meet caloric needs of debilitated patients
- **55 grams of protein per liter**  
designed to compensate for the increased protein requirements associated with acute stress or chronic malnutrition
- **Balanced caloric distribution**  
ample carbohydrate and fat are provided to spare protein for tissue synthesis and repair... appropriate calorie/nitrogen ratio permits the efficient utilization of protein
- **Lactose-free**  
will not contribute to lactose-associated diarrhea
- **Convenient, ready-to-use liquid**  
available in E-Z Open 8 fl oz cans (Vanilla)... additional flavors (Orange, Strawberry, Pecan, Lemon, Cherry) are available when Vari-Flavors® Flavor Packs are mixed with Ensure Plus



When utilized to provide total nutrition, orally or by gavage tube, ENSURE PLUS can deliver the high-calorie intakes required by severely ill or traumatized patients who are nutritionally depleted, and yet reduce the potential for problems often associated with large-volume intakes. As a dietary supplement, ENSURE PLUS can supply extra calories and protein for patients unable or unwilling to consume adequate nutrition.

**ROSS LABORATORIES**  
COLUMBUS, OHIO 43216  
Division of Abbott Laboratories, USA  
Makers of Ensure® Liquid Nutrition  
and Polyose® Glucose Polymers



## Obituaries

\*Edwards, Samuel, Chicago, died March 15 at the age of 48. Doctor Edwards was a 1963 graduate of Howard University in Washington.

\*Gill, Frank T., Oak Park, died March 14 at the age of 61. Doctor Gill was a 1939 graduate of Loyola University, Stritch School of Medicine.

\*Hollander, Erich, Chicago, died January 7 at the age of 81. Doctor Hollander was a 1932 graduate of Johann Wolfgang Goethe University, Germany.

\*Kolís, Julius A., Sterling, died January 29th at the age of 57. Doctor Kolís was a 1950 graduate of the University of Frankfort, Germany.

\*Koluvek, Otto C., Berwyn, died April 11 at the age of 70. Doctor Koluvek was a 1933 graduate of the Chicago Medical School.

\*Lim, Jesus S., Chicago, died April 4 at the age of 40. Doctor Lim was a 1961 graduate of the University of St. Thomas.

\*Maydet, Simon J., Chicago, died March 8 at the age of 65. Doctor Maydet was a 1937 graduate of the University of Illinois.

\*Murphy, Virgil Leroy, Georgetown, died February 28 at the age of 79. Doctor Murphy was a 1930 graduate of the University of Illinois.

\*Nagle, Richard A., Chicago, died April 11 at the age of 84. Doctor Nagle was a 1917 graduate of Loyola University, Stritch School of Medicine.

\*Schroeder, Marion Cole, Miami, Florida, formerly of Chicago, died March 6 at the age of 83. Doctor Schroeder was a 1919 graduate of Rush Medical College.

\*Studer, Edward F., Tuscon, Arizona, formerly of Chicago, died March 5 at the age of 85. Doctor Studer was a 1920 graduate of Rush Medical School.

\*Todd, Leonard F., Alton, died April 3 at the age of 43. Doctor Todd was a 1959 graduate of the University of Illinois.

\*Indicates ISMS member.

\*Indicates member of the ISMS Fifty Year Club.

### Correction

The March issue of IMJ incorrectly listed the graduation date for William A. Meadows, M.D., Lockport, who died January 18th at the age of 72. Doctor Meadows graduated from the University of Alberta, Canada, in 1932. We regret this error.

## MANUSCRIPT INFORMATION

Original articles will be considered for publication with the understanding that they are contributed only to the *Illinois Medical Journal*. The *Journal* assumes no responsibility for the opinions and claims expressed in the articles contributed.

Manuscripts should be typed, double spaced, and submitted in duplicate, one original and one carbon. An article should not exceed **12 to 16 manuscript pages**, (including illustrations) and should be briefer if possible. Please enclose personal glossy photos of author or authors. Snapshots are not suitable for reproduction.

References should be numbered in order of appearance in the text and conform to the following style in the order given: name of author, title of article, name of periodical with volume, page, month (day of month if weekly) and year. The *Journal* does not assume responsibility for the accuracy of

references used with articles.

The first page should list the title, the name of the author(s), degrees and any institutional or other credits as well as the author's mailing address. The title should be as short as possible. Pages should be numbered consecutively. Tables are to be typed, numbered and accompanied by a brief descriptive title. Make drawings and charts in black ink. If photographs are submitted, send black and white glossies. Number illustrations consecutively and indicate their place in the text. Number, indicate the top and place the author's name on the back of each illustration.

Address manuscripts to:

*Illinois Medical Journal*  
55 E. Monroe St., Suite 3510  
Chicago, Ill. 60603

# THERE ARE A LOT OF PEOPLE GETTING BETWEEN YOU AND YOUR PATIENT.

Medicine today is in the spotlight, subjected to all kinds of scrutiny. Your control over patient therapy is being monitored, judged and occasionally abrogated, sometimes by unknown third parties.

The worry is that in the wake of this focus, the relationship between you and your patient will be weakened, without offsetting benefits. Consider three examples:

**Drug substitution** In most states, pharmacy laws, regulations or professional custom stipulate that your non-generic prescriptions be filled with the precise products you prescribe. But in the last five years, a dozen or more State laws have been changed, permitting the pharmacist in most cases to select a product of the same generic drug to fill any prescription.

Ironically, this dilution of physician control has taken place against a background of growing evidence that purportedly equivalent drug products may be inequivalent, since neither present drug standards nor their enforcement are optimal. In fact, the FDA itself says it has not enforced the same standards for hundreds of "follow-on" products that it had applied to the original NDA approvals. Thus physician control over patient therapy is being eroded with a risk that patients may be exposed to drugs of uncertain quality.

The major advertised claim for substitution is reduced prescription prices for consumers. Yet no documentation of any significant savings has been produced.

**MAC** Maximum Allowable Cost, MAC for short, is a Federal regulation designed to cut the Government's drug bill by setting price ceilings for drugs dispensed to Medicare and Medicaid patients. Unless the prescriber certifies on the prescription that a particular product is medically necessary, the Government intends to pay only for the cost of the lowest-priced, purportedly-equivalent,

generally-available product. The effect of the program may be that elderly and indigent patients will be restricted to products which someone in Washington believes are priced right. Practicing doctors will have little to say about administration of the program, since Government will have absolute authority to make its choices stick.

**The drug lag** The future of drug and device research depends upon a scientific and regulatory environment that encourages therapeutic innovations. The American pharmaceutical industry annually is spending more than \$1 billion of its own funds and evaluating more than 1,200 investigational compounds in clinical research. Disease targets include cancer, atherosclerosis, viruses and central nervous system disorders, among others. But there is a major barrier to the flow of new drugs to your patients: The cost of the research is more than ten times what it was, per product, in 1962; and whereas governmental clearance of new drug applications took six months then, it commonly consumes two years now.

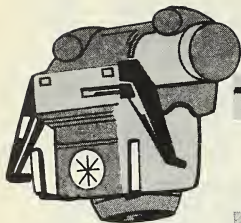
The FDA needs adequate time, of course, to consider data. But it is equally clear that the present approval process contributes to needless delay of needed therapy. That's why the increased efficiency of the drug approval process is vital to all our futures.

If these issues concern you, we suggest that you make your voice heard—among your colleagues and your representatives in State legislatures and in Washington.

It could make a difference in your practice tomorrow.



Pharmaceutical Manufacturers Association  
1155 Fifteenth Street, N.W., Washington, D.C. 20005



## the view box

LEON LOVE, M.D./CHAIRMAN/DEPARTMENT OF RADIOLOGY  
LOYOLA UNIVERSITY STRITCH SCHOOL OF MEDICINE

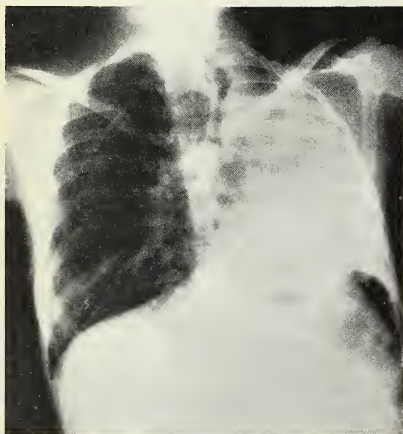


Figure 1



Figure 2

This patient is an 18-year-old female who presented with a routine preoperative chest. What's your diagnosis?

1. Pneumonectomy
2. Agensis
3. Atelectasis from a foreign body
4. Fibrothorax from old tuberculosis

*(Answers on page 391)*



## Clinics for Crippled Children

### Listed for June

Thirty-four clinics for Illinois' physically handicapped children have been scheduled for June by the University of Illinois, Division of Services for Crippled Children. The Division will count twenty-five general clinics providing diagnostic, orthopedic, pediatric, speech and hearing examination, along with medical, social and nursing services. There will be eight special clinics for children with cardiac conditions and one for children with cerebral palsy. Any private physician may refer to or bring to a convenient clinic any child or children for whom he may want examination or consultative services.

- June 1 Jacksonville, Passavant Hospital
- June 1 Hinsdale, Hinsdale Hospital
- June 2 Sterling, Community General Hospital
- June 2 West Frankfort, Union Hospital
- June 2 Flora, Clay County Hospital
- June 2 Lake County Cardiac, Victory Memorial Hospital
- June 3 Division Cardiac, U. of I. at the Medical Center
- June 7 East St. Louis, Christian Welfare Hospital
- June 8 Springfield Pediatric Neurology, St. John's Hospital
- June 8 Carmi, Carmi Township Hospital
- June 8 Champaign-Urbana, McKinley Hospital
- June 8 Joliet, St. Joseph's Hospital
- June 8 Elgin, Sherman Hospital
- June 9 Kankakee, St. Mary's Hospital
- June 10 Chicago Heights Cardiac, St. James Hospital
- June 13 Peoria, Cardiac, St. Francis Hospital
- June 14 Belleville, St. Elizabeth's Hospital
- June 14 Peoria, St. Francis Hospital
- June 15 Chicago Heights General, St. James Hospital
- June 16 Rockford, St. Anthony's Hospital
- June 16 Springfield, St. John's Hospital
- June 16 Bloomington, Mennonite Hospital
- June 16 Elmhurst Cardiac, Memorial Hospital of DuPage County
- June 20 Maywood, Loyola Medical Center
- June 21 Alton, Alton Memorial Hospital
- June 21 Rock Island, Moline Public Hospital
- June 22 Aurora, St. Joseph Mercy Hospital
- June 24 Evanston, St. Francis Hospital
- June 24 Chicago Heights Cardiac, St. James Hospital
- June 27 Peoria Cardiac, St. Francis Hospital
- June 28 Peoria, St. Francis Hospital
- June 28 Danville, Lake View Hospital
- June 28 Park Ridge Cardiac, Lutheran General Hospital
- June 30 DuQuoin, Marshall Browning Hospital

The Division of Services for Crippled Children is the official state agency established to provide medical, surgical, corrective and other services and facilities for diagnosis, hospitalization and after-care for children with crippling conditions or who are suffering from conditions that may lead to crippling. In carrying on its program, the Division works cooperatively with local medical societies, hospitals, the Illinois Children's Hospital-School, civic and fraternal clubs, visiting nurse's association, local, social and welfare agencies, local chapters of the National Foundation and other interested groups. In all cases the work of the Division is intended to extend and supplement, not supplant, activities of other agencies, either public or private, state or local, carried on in behalf of crippled children.

## Do you have patients with Paget's Disease of Bone?



You can get updated information on the disease and on effective treatment for its symptoms of bone pain, skeletal deformities, and neurologic deficits.

Just send the coupon below.



Armour Pharmaceutical Company  
Greyhound Tower  
111 West Clarendon Avenue  
Phoenix, Arizona 85077

- ☐ Send latest information on Paget's Disease of Bone.
- ☐ Have your representative call on me.

Dr. \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_

State \_\_\_\_\_

Zip \_\_\_\_\_





## report

Illinois Society  
American Association of Medical Assistants

# Annual Medical Assistants Workshop



(l-r) Beverly C. Hall, Ruby Jackson, Illinois Society AAMA President, Alice Tuma, and Cecilia Kenny, inside the Illinois Society, AAMA Booth at the Midwest Clinical Conference.

The Seventh Annual Medical Assistants Workshop at the Midwest Clinical Conference was held at McCormick Place on Wednesday, March 2, 1977.

The educational sessions consisted of:

1. "Assertiveness Training" by Jane E. Meyers, M.A. CSW.
2. "Disability Process: Who-What-When" by Bernard Levine, Ph.D., Director of Psychological Services, Rehabilitation Institute of Chicago. (A.A.M.A. approval for CEU credits pending.)

There were many membership inquiries at the Medical Assistants' booth from both doctors and students.

Many thanks to those who assisted at the booth. We are grateful to the Merck Sharp and Dohme Company for lending us the display and making the booth a success.

For further information regarding the Illinois Society of AAMA, please contact 1st Vice President Jean Nelson, 829 Carnaby Court, Schaumburg, IL 60172, or 2nd Vice President Velma Hukill, 115 N. Fourth St., Cuba, IL 61427.



Illinois Society, AAMA Booth at the Midwest Clinical Conference, March 2, 1977, McCormick Place, Chicago.

For lungs that need  
all the help you can give them  
in the treatment of  
chronic bronchitis/emphysema  
**Bronkotabs®**

ephedrine/theophylline/guaifenesin (glyceryl guaiaacolate)/phenobarbital



Potent bronchodilation and rapid reduction of bronchial edema.

Efficient expectorant action thins and loosens tenacious  
mucus to facilitate its removal.

Gentle sedation produces mild calming action.

*To prevent or relieve symptoms in asthma, chronic bronchitis, emphysema*

## **BRONKOTABS®**

Each tablet contains ephedrine sulfate 24 mg; guaifenesin (glyceryl guaiaacolate) 100 mg; theophylline 100 mg; phenobarbital 8 mg (warning: may be habit-forming).

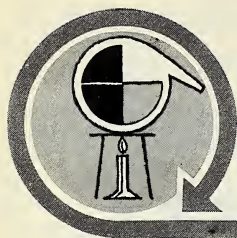
**PRECAUTIONS:** With Bronkotabs therapy, sympathomimetic side effects are minimal. However, frequent or prolonged use may cause nervousness, restlessness, or sleeplessness. Bronkotabs should be used with caution in the presence of hypertension, heart disease, or hyperthyroidism. Drowsiness may occur. Ephedrine may cause urinary retention, especially in the presence of partial obstruction, as in prostatism.

**RECOMMENDED DOSAGE:** One tablet every 3 or 4 hours, not to exceed five times daily. Children over 6: one half adult dose.

**SUPPLIED:** Bottles of 100 and 1000 scored tablets.

**BRON**

**LABORATORIES INC.** • 90 Park Avenue, New York, N.Y. 10016



# new pharmaceutical specialties

By PAUL DEHAEN

For detailed information regarding indications, dosage, contraindications and adverse reactions, refer to the manufacturer's package insert or brochure.

**New Single Drugs**—Drugs not previously known, including new salts.

**Duplicate Single Drugs**—Drugs marketed by more than one manufacturer.

**Combination Products**—Drugs consisting of two or more active ingredients.

**New Dosage Forms**—Of a previously introduced product.

The following new drugs have been marketed:

## NEW SINGLE DRUGS

**DUPHALAC** Nutrient Rx  
Manufacturer: Philips Roxane Laboratories, Inc.  
Nonproprietary Name: Lactulose  
Indications: Portal systemic encephalopathy  
Dosage: Set package insert  
Supplied: Syrup, bottles 30, 45 and 500 ml

**LORELCO** Cholesterol Reducing Agent Rx  
Manufacturer: Dow Pharmaceuticals  
Nonproprietary Name: Probucol  
Indications: Adjunctive therapy to diet for the reduction of elevated serum cholesterol  
Dosage: Two tablets twice daily  
Supplied: Film coated tablets, 250 mg

## DUPLICATE SINGLE DRUGS

**PEBSR** Antihistamine Rx  
Manufacturer: CIBA Pharmaceutical Co.  
Nonproprietary Name: Triphenylamine HCl  
Indications: Perennial and seasonal vasomotor rhinitis  
Dosage: Individualized; one tablet in the morning and one in the evening. In difficult cases, one tablet every eight hours. Not for use in children.  
Supplied: Sustained release tablets, 100 mg

**RECTOID** Corticosteroid Rx  
Manufacturer: Pharmacia Laboratories  
Nonproprietary Name: Hydrocortisone  
Indications: Adjunctive therapy in ulcerative colitis  
Dosage: One enema nightly for 21 days  
Supplied: Enema, 100 mg

## COMBINATION PRODUCTS

**DEAPARIL-ST** Geriatric Modifier Rx  
Manufacturer: Mead Johnson Laboratories  
Indications: Dizziness and confusion of the elderly

Composition: Dihydroergocornine 0.33 mg  
Dihydroergocristine 0.33 mg  
Dihydroergokryptine 0.33 mg  
Dosage: One tablet three times daily  
Supplied: Sublingual tablets, 1 mg

**RYNA-C Syrup** Cough Syrup o.t.c.-V  
Manufacturer: Mallinckrodt Pharmaceuticals  
Composition: 5 ml contains:

Codeine Phosphate 10 mg  
Pseudoephedrine HCl 30 mg  
Chlorpheniramine Maleate 2 mg  
Indications: Temporary relief of symptoms of cough, nasal congestion and sneezing  
Dosage: Adults: 2 tsp q-4h  
Children 5-12 yrs.: 1 tsp q-4h  
Supplied: Syrup, 1 pt.

## NEW DOSAGE FORMS

**AFRIN Pediatric** Nasal Decongestant o.t.c.  
Nose Drops  
Manufacturer: Schering Laboratories  
Indications: Relief of nasal congestion in a variety of conditions  
Administration: Twice a day, morning and at bedtime  
Supplied: Nose drops, 0.025%

## NEW DOSAGE FORMS

**CHLORASEPTIC** Cough Preparation o.t.c.  
**DM LOZENGES**  
Manufacturer: Eaton Laboratories  
Composition: Dextromorphan Hydrobromide 10 mg

Phenol 32.5%  
Indications: Temporary relief of cough and minor sore throat pain  
Dosage: As needed  
Supplied: Lozenges

**FLUOGEN-B** Influenza Virus Vaccine Rx  
Manufacturer: Parke-Davis  
Nonproprietary Name: Influenza Virus Vaccine Monovalent, Type B

Indications: Production of immunity to influenza virus 1976  
Dosage: sc or im, exact amounts for infant, children and adults given in package insert  
Supplied: Vials, 5 ml

**contains no aspirin**

tablets

# **Darvocet-N<sup>®</sup> 100**

100 mg. Darvon-N<sup>®</sup> (propoxyphene napsylate)  
650 mg. acetaminophen



Additional information available to the profession on  
request from Eli Lilly and Company  
Indianapolis, Indiana 46206

*Lilly*

Eli Lilly and Company, Inc.  
Carolina, Puerto Rico 00630





## membership forum

*Membership Forum is intended to serve as a communicative tool for ISMS Membership. The Editors encourage comment and criticism on issues of the day. Correspondence should be addressed to: IMJ, 55 E. Monroe, Suite 3510, Chicago 60603.*

# Whither Goest the Doctor's Duty?

BY LEONARD BERLIN, M.D./SKOKIE

*"The law requires a physician to possess the skill and learning which is possessed by the average member of the medical profession in good standing, and to apply that skill and learning with ordinary reasonable care. He is not liable for a mere error in judgment, provided he does what he thinks is best after a careful examination. He does not guarantee a good result."*

New York State Supreme Court, 1905  
(*MacKenzie v. Carman*, 103 App Div 246, 92 NYS 1063)

The chief of diagnostic radiology at a university-affiliated Chicago Hospital was recently found "guilty" of malpractice for allegedly "missing" a diagnosis of carcinoma of the lung on a chest radiograph. The radiologist admitted that he failed to "see" an abnormal density on the radiograph, despite his usual and customary careful inspection. The diagnosis of lung cancer was made at a later date, and the patient eventually died. A jury awarded the patient's family \$475,000.

Recently a federal appeals court in Chicago upheld a lower court's judgment of \$250,000 against a surgeon for malpractice. The surgeon had been found "guilty" because he had incor-

rectly diagnosed a patient's abdominal symptoms as being due to cholecystitis rather than acute appendicitis.

"Malpractice" is defined legally as a "breach of a doctor's duty to his patient." In the above cases, the doctors admitted making errors in diagnoses. The juries in these cases and in many other similar cases around the nation, equated an "error" with "malpractice." In essence, these juries determined that the duty of the doctor is to perform error-free, and that therefore any error committed by the doctor is a breach of his duty.

Does the physician indeed owe his patient the duty not to make a mistake? Just what is the doctor's duty?

The medical profession has traditionally used as a basis for its code of duties, ethics, and behavior, such classical works as the Oath of Hippocrates and the Prayer of Maimonides. In recent years there has been an updating of these codes by the World Medical Association and the American Medical Association. A careful reading of both the older and the newer codes with regard to the duties of physicians fails to disclose any statement requiring a doctor to be absolutely correct, errorless, or perfect. On the subject of the duties of doctors, the various sources referred to say the following:

*Oath of Hippocrates* (400 BC): "I will allow that method of treatment

which, according to my ability and judgment, I consider for the benefit of my patients."

*Prayer of Maimonides* (13th Century AD): "Never allow the thought to arise in me that I have attained to sufficient knowledge, but vouch-safe to me the strength and the ambition ever to extend my knowledge, for the mind of man is ever expanding."

*World Medical Association Declaration* (Geneva, 1948): "I will practice my profession with conscience and dignity."

*American Medical Association Principles of Medical Ethics*: "The principle objective of the medical profession is to render service to humanity with full respect for the dignity of man."

The courts long ago set up two basic requirements for physicians, both of which hold true even today; firstly, a physician must be competent in his specific field, and he must possess adequate knowledge. Secondly, he must apply his knowledge and skill according to the standards imposed upon him by his peers. These requirements are perfectly consistent with the medical profession's own concepts of ethical conduct and behavior. Both our own profession and the courts would hold that no doctor should extend himself beyond his training, experience, and level of competence (except in certain emergency situations), and that no doctor should perform in a manner less than the accepted norm. Injuries to patients caused by the untrained generalist who electively attempts to deliver an abnormally positioned fetus, the surgeon who operates in an inebriated state, the anesthesiologist who is puffing on a cigarette outside the operating room, and the internist who treats a patient without first performing an adequate physical exam, constitute malpractice in the eyes of both the legal and the medical professions.

However, it is alarming to observe that in the past few years, the concept of a doctor's duty has undergone a remarkable change. The duty to "be correct" has somehow slipped into the realm of required conduct on the part of the physician. Appeals courts in every state, over the years, have consistently agreed with the New York Supreme Court's statement regarding the duties of doctors, quoted at the

beginning of this article. In 1954, the Illinois appellate court said it this way: "If the doctor has given the patient the benefit of his best judgment, assuming that judgment to be equal to that ordinarily used by reasonably well-qualified doctors in similar cases, he is not liable for negligence, even if that judgment is erroneous" (*Wade v. Ravenswood Hospital*, 3 Ill. App. 2d 102, 120 N.E. 2d 345). Eleven years later, the Illinois appellate court added, "Proof of a bad result or a mishap is no evidence of lack of skill or negligence" (*Scardina v. Colletti*, 63 Ill. App. 2d 481, 211 N.E. 2d 762).

In recent years, these higher court pronouncements seem to have been ignored all too frequently at the trial court and the pre-trial court levels. For as the radiologist's and the surgeon's cases referred to above suggest, *the mere occurrence of an error by the doctor*, coupled with a "poor result," is more than enough to obtain a jury verdict of malpractice, or a significant financial settlement, in most cases, *without the need of proving negligence*.

Most physicians, upon accepting their M.D. degrees, accepted with them the traditional responsibilities to be knowledgeable, skillful, honest, and to do the very best job of practicing medicine that they can. All physicians recognize the requirements that they possess and apply ordinary skill and learning, and that their diagnoses and therapies must conform to the standards of the medical community. However, recognizing that medicine is more an art than a science, most physicians may be unwilling to accept the additional duty and obligation to be *correct*. If the duty of *being right* continues to be imposed on the doctors, then the number of malpractice lawsuits against physicians will continue to rise unabated.

The poet Samuel Butler wrote, "In practice it is seldom very hard to do one's duty when one knows what it is, but it is sometimes exceedingly difficult to find this out."

Whither goes the doctor's duty? Will it return to the concepts of Hippocrates and Maimonides, or will it be expanded into even more intolerable waters by our legal system? The state of health of the medical profession, and indeed of society, depends on the answer.

## On Cooperation . . .

Joseph Skom, M.D., *President*,  
Illinois State Medical Society

Dear Dr. Skom:

May I express my heartiest thanks to you and the Illinois State Medical Society for providing volunteer medical coverage at our state facilities during the recent crisis.

Your actions did much to establish a new partnership between the public and the private sectors in a time of need.

I look forward to working with you on the Governor's Task Force to bring about a permanent solution to this very thorny problem.

Sincerely,  
Robert deVito, M.D.  
Director—DMHDD

## But Then Again . . .

*An article carried in the January IMJ (151:1, 31) "School Screening for Scoliosis," by Daniel C. Newman, M.D., and Ronald L. DeWald, M.D., prompted a response in the March IMJ Membership Forum (151:3, 222). The following is Dr. DeWald's rebuttal to the rebuttal carried in March.*

Dear Editors:

I wasn't sure if the letter by Dr. Baggot deserved a reply or not; however, I feel that he has made such inflammatory statements that I must have rebuttal.

Certainly, thoracogenic scoliosis is known to orthopedic surgeons who treat scoliosis. It is very rare (Reference #18).

To state that all scoliosis is a result of intrathoracic problems, simply isn't true. How could one possibly explain experimental scoliosis? (References #1-#17).

It is true that the exact etiology of the most common scoliosis is unknown, thus the name idiopathic scoliosis. This most common type of scoliosis usually starts in adolescents who previously had a straight spine. Are we to assume that something happens to the internal organs at this particular age?

The statement that patients do not do well when their spine is straightened is reactionary and must have been

made by one who is not familiar with the current literature on scoliosis.

Sincerely,  
 Ronald L. DeWald, M.D.  
 Professor, Orthopedic Surgery  
 Rush Medical College

#### References:

1. Alexander, M. A., Bunch, W. H., Ebbesson, S. O. E.: "Can Experimental Dorsal Rhizotomy Produce Scoliosis," *J. Bone Joint Surg. (Am.)* 54:1509-1513, 1972.
2. Beals, R. K.: "Nosologic and Genetic Aspects of Scoliosis," *Clin. Orthop.* 93:23-32, 1973.
3. Cowell, H. R., Hall, J. N., MacEwen, G. D.: "Genetic Aspects of Idiopathic Scoliosis," *Clin. Orthop.* 86:121-131, 1972.
4. Fry, P., Harkness, M. L. R., Harkness, R. D., Nightingale, M.: "Mechanical Properties of Tissues of Lathyrus Animals," *J. Physiol. (London)* 164:77, 1962.
5. James, J. I. P.: "The Etiology of Scoliosis," *J. Bone Joint Surg. (Br.)* 52:410-419, 1970.
6. Karaharju, E. O.: "Deformation of Vertebrae in Experimental Scoliosis. The Course of Bone Adaptation and Modeling in Scoliosis With Reference to the Normal Growth of the Vertebra," *Acta. Orthop. Scand. (Suppl)* 105:1-87, 1967.
7. Kazmin, A. I., Merkureva, R. V.: "Role of Disturbances of Glucosaminoglycane Metabolism in the Pathogenesis of Scoliosis," *Ortop. Travm. Protez.* 32:87-91.
8. Langenskiold, A., Michelsson, J.-E.: "The Pathogenesis of Experimental Progressive Scoliosis," *Acta. Orthop. Scand. (Suppl)* 59:1-26, 1962.
9. Langenskiold, A.: A SUMMARY OF 16 YEARS' EXPERIMENTAL RESEARCH ON THE PATHOGENESIS OF SCOLIOSIS, Chap 19, pp 163-171. Fidler, M. W., Jowett, R. L., Troup, J. D. G.: HISTOCHEMICAL STUDY OF THE FUNCTION OF MULTIFIDUS IN SCOLIOSIS, Chap 22. SCOLIOSIS AND MUSCLE. PROCEEDINGS OF A FOURTH SYMPOSIUM, LONDON, NOVEMBER 1973. Edited by P. A. Zorab. London, W. Heinemann Medical Books Ltd., 1974, pp 184-192.
10. Liszka, O.: "Spinal Cord Mechanisms Leading to Scoliosis in Animal Experiments," *Acta. Med. Pol.* 2:45-64, 1961.
11. MacEwen, G. D.: "Experimental Scoliosis," *Israel J. Med. Sci.* 9:714-718, 1973.
12. Michelsson, J.-E.: "The Development of Spinal Deformation in Experimental Scoliosis," *Acta. Orthop. Scand. (Suppl.)* 81:1-91, 1965.
13. Ponseti, I. V.: "Skeletal Lesions Produced by Aminonitriles," *Clin. Orthop.* 9:131-144, 1957.
14. Robin, G. C., Stein, H.: "Experimental Scoliosis in Primates," *J. Bone Joint Surg. (Br.)* 57:142-145, 1975.
15. Veliskakis, K. P.: "Increased Generalized Ligamentous Laxity in Idiopathic Scoliosis," *J. Bone Joint Surg. (Am.)* 55:435, 1973.
16. Wynne-Davies, R.: GENETIC AND OTHER FACTORS IN THE ETIOLOGY OF SCOLIOSIS. University of Edinburgh, Edinburgh, 1973 (Thesis).
17. Yamada, K., Yamamoto, H., Tamura, T., Tezuka, A.: "Development of Scoliosis Under Neurological Basis, Particularly in Relation with Brain-Stem Abnormalities," *J. Bone Joint Surg. (Am.)*
18. Stauffer, E. S., Mankin, H. J.: "Scoliosis After Thoracoplasty. A Study of Thirty Patients," *J. Bone Joint Surg. (Am.)* 48:339-348, 1966.

## Cut the Risk of a Malpractice Suit Make an ISMS Action Call 312/782-1722

The ISMS ACTION CALL telephone information system gives you access to a constantly expanding library of taped messages which can help you minimize your chances of being sued. The library also contains tapes which outline what to do if you are sued and how to counter frivolous litigation.

You can consult the ISMS ACTION CALL tape library between 9 a.m. and 4:30 p.m., Monday through Friday. Dial (312) 782-1722 and ask for the tape by number.

### No. PREVENTION/DEFENSE

1. Communication Can Prevent Litigation
2. Medical Records . . . A Key to Your Defense
3. Good Prescribing Habits Can Keep You Out of Court
4. Obtaining Patient Consent That Will Stand Up in Court
5. Parental Consent in Treatment of Minors . . . When It's Needed

### SUITS/INSURANCE

6. What Happens When You're Sued
7. Dangers of Dropping Malpractice Coverage

### COUNTER MOVES

8. Filing a Countersuit
9. Recovering Defense Costs Through Section 41
10. Initiating Disciplinary Action Against Attorneys



# What's new at Bio-Science Chicago?

**Always the latest specialized diagnostic tests.**

## **Chemistry**

Anti-convulsant group  
Cadmium in blood  
Darvon®  
Ferritin in serum  
Free erythrocyte protoporphyrins  
Pyridoxal phosphate (B<sub>6</sub>)  
Riboflavin (B<sub>2</sub>)  
Succinimides in serum  
Theophylline by HPLC  
Uroporphyrinogen-1-synthetase

## **Endocrinology**

Androstenedione in serum  
Calcitonin  
C-peptide  
Estril in serum  
Placental Estril in urine  
HCG-  $\beta$ - subunit  
Pregnanetriol in urine (GLC)  
Prolactin  
17-OH Progesterone in serum  
Thyroglobulin in serum

## **Immunochemistry**

Anti-extractable nuclear antigen (Anti-ENA)  
Beta 2-microglobulin  
Fungus antibody group  
Gentamicin  
Intrinsic factor antibodies  
Tobramycin  
Anti-tissue antibodies

For information contact:  
James A. Inkpen, Ph.D., Director



**Bio-Science  
Laboratories**

Chicago Branch  
770 Burr Oak Drive  
Westmont, IL 60559  
(312) 887-9800



# Physician Recruitment Program

*In an effort to reduce the number of towns in Illinois needing physicians, the Physician Recruitment Program and the Doctor's Job Fair, are publishing synopses in the Journal.*

*Physicians who are seeking a place to practice or who know of any out-of-state physicians seeking an Illinois residence are asked to notify the Program.*

*Any areas wishing to be listed should contact: Mrs. E. Duffy, Physician Recruitment Program, ISMS, 55 E. Monroe, Suite 3510, Chicago, 60603.*

**BEMENT:** Population around 1800. Take over established practice of 30 years. Complete office facilities. Financial assistance available. New nursing home. New hospital and nursing home 7 miles. Located 25 miles from Decatur, 30 miles from Champaign hospitals. Choice of newly decorated home city or country. Contact: Mayor J. E. Hargrave, 633 E. Bodman, Bement, 217-678-8186 or Dr. Wm. Scott, 107 E. Bodman, Bement, 217-678-5151. (9)

**CAIRO:** Community Hospital with 20,000 population, staff of 1 Dentist, 1 Pediatrician, 1 OB/GYN, 2 General Surgeons, 1 Internist seeking ambitious General Practitioner for rural community. Recreation, (boating, fishing on lakes, rivers; golf, tennis), education, (public, private and parochial). Financial assistance in moving, office space, staff. Excellent potential. Contact: Harvey Pettry, PADCO Community Hospital, Cairo, 62914. 618-734-2400. (5)

**CANTON:** Clinic established in 1937 serving the Spoon River Valley area. This multi-specialty clinic is located in a clinic building constructed in 1969, located two blocks from 250-bed hospital. Twelve physician group. 30 miles from Peoria School of Medicine. Contact: Harlan Crouch, 175 S. Main, Canton, 61520. 309-647-0201. (8)

**CARBONDALE:** Family Physician: Innovative neighborhood center in Southern Illinois seeks family practice physician to provide patient care and supervise other professionals and paraprofessionals in a clinic setting. Salary negotiable. Position available March, 1977. Contact: Robert Stalls, Director of Human Resources, City of Carbondale, 609 E. College, Carbondale, (618-549-5302). (6)

**CARTHAGE:** County Seat for Hancock County (Population 24,000). Need for Internist, Family Practice, and ER Physicians willing to conduct family practice. Memorial Hospital will guarantee first year income and provide office space. Four physicians and two surgeons at present. Contact: Harold A. Dietz, Administrator, Memorial Hospital, Carthage, 62321. 217-357-3131. (5)

**CHADWICK:** Rural area in northwestern corner of Illinois. Population 600. Strong farming community. Need general practitioner to set up solo practice. Office facilities available. Contact: Harold Frank, Box 38, Chadwick, 61014. (815) 684-5154 or 684-5147. (5)

**CHICAGO:** Progressive Community Hospital with active Emergency Department seeking an Orthopedic Surgeon. Good facilities available. Financial package attractive. Contact: Joel V. Bailey, 326 West 64th Street, Chicago 60621-312-962-4100. (8)

**CHICAGO** (desirable suburb): Older general practitioner has excellent office facilities to share with younger G.P. Objective: need help with practice. Younger man may have guarantee to take over practice in near future. Hospital staff appointment available. All replies confidential. Box MK, Physician Recruitment Program, ISMS. (9)

**CHICAGO** (Near North): Part time physician in advisory capacity for new not-for-profit HOME HEALTH CARE facility. Several hours per month of consulting services. No treatment of patients. Illinois license required. Salary negotiable. Contact: Thomas Bassman, 1255 N. Sandburg Terrace, Chicago, 60610, AC 312-337-7900. (9)

**CHICAGO:** Take over large general practice. No investment required. Modern fully equipped and staffed facility. Salary and profit sharing. Contact: Jack Pardee, Suite 300, 2400 E. Devon, Des Plaines 60018. 312-298-3500. (9)

**CHICAGO:** Medical Center with complete facilities needs physician full time for welfare practice. Part time hours are also available. Above average earnings obtainable. Contact: Mohawk Medical Center, 832 West Madison Street, Chicago, Illinois 60607. (312) 421-2199. (9)

**CHICAGO HEIGHTS:** 35 man multispecialty group needs Board certified or eligible family practitioner. Located in 100,000 sq. ft. building. Ancillary services available include X-ray, lab, cardiology stress testing, physical therapy, speech therapy, biofeedback, optical shop, pharmacy. Plans for further expansion with investment opportunities. Call Mr. H. Cloys, 333 Dixie Hwy., Chicago Heights, 60411. 312-756-7447. (5)

**EAST CHICAGO:** Large industrial facility located in northwestern Indiana has an immediate opening for a medical director. You will supervise a medical facility and experienced staff and play an active role on the management team. The position offers excellent salary and fringe benefits. M.D. required. An equal opportunity employer-M/F. Please reply to: Box MW, Physician Recruitment Program, ISMS. (9)

**FAIRBURY:** population 3,500; fully accredited modern hospital in progressive rural community located 100 miles southwest of Chicago servicing 15,000. Housing, office, and financial assistance available. Only five general practitioners and one board eligible surgeon serving area. Contact Donald Patterson, Administrator; Fairbury Hospital, 519 South Fifth Street, Fairbury, 61739, (815) 692-2346. (8)

**FORT MADISON, IOWA:** Openings for 2 FP/GP, OB, PED., Int. in growing industrial city of 16,000 serving 70,000 on Miss. River. Solo, partnership, clinic available. Substantial salary, other incentives. U. of Ia. near. Excellent living area, 125 bed accredited hospital. Contact: Donald A. Buckert, Sacred Heart Hospital, Fort Madison, Ia. 52627. 319-372-6530. (5)

**HERRIN:** Trade area of 40,000. Sportsman's paradise of Southern Illinois. 20 minutes from S.I.U. and Medical School. Internal Medicine and Family Practice needed now. Partnerships and solo available. Modern office facilities. Financial assistance. Contact: Larry Fell, Herrin Hospital, Herrin, 62948. (618) 942-4710. (5)

**HINSDALE:** Seeking physicians for church-related, fee-for-service, family health centers in Chicago western suburbs. Competitive salary, facilities, equipment, malpractice insurance included. Continuing education, patient education, counseling staff, teaching of medical students and residents. Contact: Bill Peterson, Pastoral Director, Wholistic Health Center, 137 S. Garfield, Hinsdale, 60521. Phone (312) 986-5252. (9)

**HOMER:** Family Practitioner—Eleventh ranking county in U.S. gross farm income; 20 min. to large town with two hospitals; drawing area 12,000; house and office building offered; town may help with equipment. Contact: Douglas Driscoll, RR2, Homer, 61849. (217) 896-2434. (5)

**ILLIOPOLIS:** Needed Family Physician for small community. Surrounding area about 6,000 population. Industrial practice possible. Twenty miles from five major hospitals, on Interstate. Financial assistance available. Will work with you on office facilities. Contact: John Burke, R.R. 1, Illiopolis, 62539. Daytime—(217) 753-4861; night—(217) 486-6009—collect. (5)

**JACKSONVILLE:** Two-college town of 26,000 needs Primary Care Physicians. Excellent opportunity for F.P.s and Internists to join young, 37-member staff, expanding hospital, and progressive medical climate where patient care is the bottom line. Med. school 35 min's with good teaching opportunities. Contact: Larry Bear, Passavant Hospital, Jacksonville, 62651. (217) 245-9541. (5)

**KANKAKEE:** Physician needed for area-wide trauma center in a 300 bed hospital. Emergency Medical training or training in primary care medicine is required. Salary commensurate with training and experience. Please contact Dr. R. Schuller at 500 West Court Street., Kankakee, Illinois 60901 or phone 815-937-2410. (6)

**KEOKUK, IOWA:** Progressive industrial community of 15,000 with 40,000 service area. Opportunities for family practice and internal medicine, solo or group practice. Complete office facilities, financial guarantee and assistance available. Located on Mighty Mississippi. Contact: Dr. Lynn L. Walker, Keokuk Area Hospital, P.O. Box 1500, Keokuk, Iowa 52632. AC 319-524-7150. (9)

**LA SALLE-PERU:** Area population 35,000. Opportunities in hospital for family practice, internal medicine, pediatrics, OB-GYN, Anesthesiologist. Twenty-five physicians at present with several over age 55. Two hours from Chicago. Office facilities. Financial assistance

available. Numerous recreational facilities, good schools and housing. Contact: W. Schweickert, 925 West Street, Peru, 61354. (815) 223-3300. (5)

**LIBERTYVILLE:** Family practice physician, G.P. or internist to join new outpatient clinic consisting of full auxiliary facilities, special procedure rooms and future outpatient surgical center. Located in a rapidly growing area near lakes, shopping centers, recreation areas and easy access to Chicago theaters, museums and cultural events. For information call 312-362-0020, write Dr. G. Gavery, 611 S. Milwaukee, Libertyville, 60048. (9)

**LITCHFIELD:** Emergency Physician Opening—Join two full-time physicians staffing a Trauma Center in new hospital. Excellent salary, flexible scheduling to allow ample time for hobbies and leisure. Comfortable community of 8,000 with beautiful 1700 acre lake bordered by wooded homesites. Community interests include boating, fishing, hunting, farming, houses, golf, tennis, private flying and amateur theatre. One hour's drive to St. Louis or Springfield. Contact: Lee Johnson, M.D. or Jim Bohl at (217) 324-2191, St. Francis Hospital, Litchfield, 62056. (5)

**MENDOTA:** (City population 8000—service area 20,000). New medical clinic building next to hospital. Small town living with social and educational benefits of Chicago and other metropolitan areas close at hand. Financial assistance available. Busy practice available. Contact: E. E. Williams, Memorial Dr. & Rt. 51, Mendota, 61342. (815) 539-7461. (5)

**MORRIS:** Orthopedist and family practitioner urgently needed. Excellent opportunities for both in this rapidly growing rural community on Interstate 80 one hour from Chicago. Accredited 75-bed general hospital with new services and equipment planned. Service area 25,000-30,000. Contact: L. Wilhelmi, M.D., P.O. Box 729, Morris, 60450. (815) 942-5474. (5)

**NEW ATHENS:** Population 2,200 (area population 17,000), 35 miles from St. Louis, Mo. Need one or two family physicians for new medical building. "Big city" attractions; best of shopping, recreation, and educational opportunities nearby. 1100 hospital beds within 20 minutes. Contact: Earl Becker, New Athens, 62264 or call collect (618) 475-2602. (5)

**OREGON:** Population 3800. Northern Illinois' most beautiful little town needs physician. On Rock River, two State Parks, 16 local industries. New Doctor with 3-year old practice would welcome associate. Great opportunity. Contact: Jean Davis, Etnyre Terrace, Oregon, 61061. Tel. 815-732-6248. (8)

**PEKIN:** Population 32,000. Hospital service area +50,000. Affiliated with Peoria School Medicine. 230-bed J.C.A.H. approved; well-equipped. Personal and capital financial assistance available. Ten miles to Peoria. Emergency services under contract. Opportunities for partnerships available. Contact: T. Larson or R. Tucker, M.D., Pekin Memorial Hospital, Pekin, 61554. (309) 347-1151. (5)

**PEORIA:** Emergency Medicine Residency Program seeks faculty for positions beginning immediately and July 1, 1977. 850 bed university affiliated hospital located in Central Illinois. Regional Trauma Center

with 45,000 undifferentiated ER patient visits annually. Positions combine academic and clinical responsibilities in developing residency program. Inquiries limited to certified/eligible primary care specialists (Internal Medicine, Pediatrics, Surgery) or graduates of ER residencies. Salary competitive with numerous fringes including malpractice. Send replies to Mr. Ronald Pechan, Assistant Administrator, St. Francis Hospital-Medical Center, 530 N.E. Glen Oak, Peoria, 61637. (309/672-2298). (8)

**PRINCETON:** New physicians offices under construction at Perry Memorial Hospital which serves Bureau County, population 40,000. Two hours southwest of Chicago. All recreational facilities available, good schools and comfortable living in country style. Contact John Revell, 606 South Main Street, Princeton, 61356. AC/815-875-4444. (6)

**ROCK ISLAND:** Excellent opportunity for family practitioners at new medical center physician's office building, rent free the first year. A substantial income guarantee and financial assistance are available. Contact: Thomas J. Lavery, Dir. Physician Recruitment, Rock Island Franciscan Hospital, 2701-17th Street, Rock Island, 61201. (309) 793-1000 (call collect). (5)

**RUSHVILLE:** Sixty miles west of Springfield. Progressive, growing community with 80 bed hospital serving population 12,000 to 15,000. Excellent schools, churches, shopping, recreation including a lake, golf course, pool, hunting and fishing. Office space with active physician, or private practice. Financial assistance. Contact:

Charles Berry Jr., Administrator, Culbertson Hospital, Rushville, 62681. (217) 322-4321. (5)

**SILVIS:** Primary Care Physicians (Family Practice, Internal Medicine, Pediatrics) wanted to locate in new medical building adjacent to suburban hospital in Illinois Quad-Cities. Guarantee offered. For additional details write or call Noel Lee, M.D., 4430-34th Avenue, Moline, 61265. (309) 797-5811. (5)

**SPRINGFIELD:** Currently seeking family practitioners, internists, and an otolaryngologist to establish practice in new Community Medical Plaza. We offer many benefits and assistance to help physicians get started. If interested, call collect: (217) 529-7151 or write to: Diana Smalley, 5230 South 6th Street-Frontage Road, Springfield, Illinois 62703. (5)

**STERLING/ROCK FALLS:** Population 28,000. Immediate need for Cardiologist (non-invasive) and E.N.T. Has progressive 167 bed JCAH hospital serving 80,000 people with unlimited growth potential, all in a pleasant community with excellent recreational facilities. Contact: Dallas K. Larson, Administrator, Community General Hospital, Sterling, 61081. (815) 625-0400. (5)

**WHITEHALL:** Area population 12,000. Urgent need for family practice or general practice. Excellent educational, cultural and recreational environment. Licensed 30 bed hospital. Office, housing, and financial assistance available. Excellent opportunity for man or woman. George A. Stahl, 407 No. Main, White Hall, 62092. (217) 374-2444. (5)

★  
*Specialized Service*

IN  
PROFESSIONAL LIABILITY INSURANCE

*is a high mark of distinction*

THE  
**MEDICAL PROTECTIVE COMPANY**  
FORT WAYNE, INDIANA

Professional Protection Exclusively since 1899

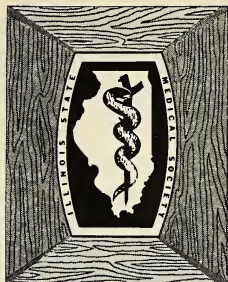
CHICAGO AREA OFFICE:

T. J. Pandak, J. C. Kunches, L. R. Gannon, and W. G. Prangle, Representatives  
814 Commerce Drive, Suite 101B, Oak Brook, Illinois 60521 (312) 325-7314

SPRINGFIELD OFFICE: W. J. Nattermann, Representative

426½ South Fifth Street, Springfield 62701 (217) 544-2251





# I M J

Illinois Medical Journal

Vol. 151, No. 5, May, 1977

## Medical Care Evaluation Studies Under The Hospital Admission And Surveillance Program

BY FRED Z. WHITE, M.D., M.A./CHILLICOTHE

*A statewide medical care evaluation (MCE) study was performed through the Hospital Admission and Surveillance Program (HASP) mechanism for each of two high incidence procedures, namely hysterectomies and T & A's. Each study was performed in conjunction with the Illinois Department of Public Health (IDPH), the Illinois Department of Public Aid (IDPA), and the Illinois Foundation for Medical Care (IFMC). Both yielded data that raised questions in regard to future studies and possibly changing patterns in care.*

### Background

HASP (Hospitalization and Surveillance Program) was formed in 1972 through agreement between the State of Illinois (IDPH and IDPA) and IFMC. Its purpose is to reduce medically unnecessary days of hospitalization, and to improve, if necessary, the quality of medical care for public aid patients. For the past four years, HASP served its function of reducing medically

unnecessary days of hospitalization through two processes:

1. Admission certification (A review of medical necessity for inpatient hospital admission.)
2. Continued stay review (A review of medical necessity for length of stay as well as for the appropriateness of the level of care.)

During this time, MCE studies at the hospital level and on a HASP regional level were performed to assess quality of care. These studies were initiated as an attempt to ascertain what patterns of care actually exist for pre-determined procedures within the state, to discover the variations from accepted criteria that might exist, and to determine if an educational program, regional or statewide, might be indicated on the basis of the data developed in the MCE study. It was not until 1976 that HASP undertook two

---

FRED Z. WHITE, M.D., is chairman of the Medical Care Evaluation Studies Subcommittee for HASP. He is the president of the Midwest Foundation for Medical Care and serves on the Medical Advisory Committee to the Illinois Department of Public Aid. In addition, Dr. White is an associate professor and faculty executive committee member at the Peoria School of Medicine. He is a recipient of the National Public Health Association Award of Merit. An ISMS Trustee, Dr. White is former medical staff president at the Methodist Medical Center of Peoria.



MCE studies on a statewide basis. This paper will concentrate on the MCE study done on hysterectomies.

Methodology

The criteria by which the MCE study was conducted were developed from the Cleveland Plan and the AMA criteria. They were reviewed by the MCE Sub-Committee of the State HASP Committee and IDPH physicians. After several revisions, criteria were selected which became the study questions. Those conducting the study were HASP coordinators already working in acute care hospitals. For many of the coordinators this was the first attempt at an MCE study, even though they were familiar with HASP's admission and length of stay certification process. The study was performed concurrently, using records that were on the floor in the nursing stations where the HASP coordinators could review them. The results—raw data—were collected centrally by the State HASP Committee. Variations, incomplete evaluation sheets, and other questions were referred back to regional groups for their comments, and for other educational use they chose to make of the data.

Data Collection

Raw data, as collected, presented many problems. Very early, it became apparent that the collection by persons unskilled in the MCE study method of auditing presented problems. Another early difficulty was that pathology reports often were not back on the chart at the nursing stations prior to discharge; thus, a pathology report was not available for the abstract sheet. Many times the coordinators did not understand the questions, and indeed, sometimes did not understand the terminology. The data, for these reasons, was of questionable validity in its raw collected state.

It also was apparent very early that the number of cases collected was at variance from the number of procedures performed during previous like time periods. The cause for this could be a Hawthorn or Halo effect: simply a degree of caution exhibited by the physicians who were aware that the study was under way. No assumption is made in this regard. However, data were submitted to determine representativeness (see Table 1). The analysis indicated that the frequency of hysterectomy was not representative of other time periods. Therefore, the results cannot be extended or transferred to other periods of time.

TABLE 1

To test the hypothesis that there is no significant difference,  $P = .01$ , between the frequency of hysterectomies during the MCE study period (12/75-2/76) and three other comparable three month periods, a  $2 \times 2$  contingency table was constructed and a Chi-test performed.

Chi-Square Formula:

$$\chi^2 = \frac{(f_1 - F_1)^2}{F_1}, \text{ d.f.} = 1$$

Where:  $f_1$  = observed frequency

Where:  $F_1$  = expected frequency

Where: d.f. = degrees of freedom

The expected frequency,  $F_1$ , is calculated from the combined sample frequencies in the usual manner. The rationale for this approach derives from our hypothesis. If there is no difference among samples, one would expect the frequencies for hysterectomies to be the same across the samples.

Time periods I, II and IV were combined into one clustered sample and compared to Period III. Total sample sizes were the respective total HASP certifications during the time periods.

Observed Frequencies			
	(f <sub>1</sub> )		
	Periods		
	I + II + IV	III	Totals
Hysterectomy	2,141	634	2,775
Non-Hysterectomy	201,673	69,805	271,478
TOTALS	203,814	70,439	274,253

Expected Frequencies			
	(F <sub>1</sub> )		
	Periods		
	I + II + IV	III	Totals
Hysterectomy	2,062	713	2,775
Non-Hysterectomy	201,752	69,726	271,478
TOTALS	203,814	70,439	274,253

(f <sub>1</sub> - F <sub>1</sub> )			
Period			
	I + II + IV	III	
Hysterectomy	+ 79	- 79	
Non-Hysterectomy	- 79	+ 79	
$\chi^2 =$	$\frac{(+ 79)^2}{2062}$	$\frac{(- 79)^2}{713}$	$\frac{(- 79)^2}{201,752}$ + $\frac{(+ 79)^2}{69,726}$
	$= 3.027$	$+ 8.753$	$+ .031$ + $.090$
	$= 11.90, P < .005$		

Therefore reject the hypothesis that there is no significant difference in frequency of hysterectomy during the MCE study period. This would indicate that unidentified variables were involved during the study period. Rejection of the hypothesis suggests that the MCE study period cannot be considered as representative of any other non-MCE three month study period.

## Discussion of the Data

With precautions and restraints on the data collected and also its validity, several areas of discussion and further study become apparent.

1. It must be remembered that this is a Medicaid population, and it cannot be assumed that it is typical or that the figures are representative for the general non-Medicaid population.
2. A comparison of the incidence of hysterectomies by years of age was made with PAS data 10 years ago (Graph No. 1). It is interesting to note that the "incidence by years" curves are very much alike except for a 4- or 5-year (year of age) time shift. This may represent altered patterns of care due to changes in needs, refinement of medical technique, or other reasons to be conjectured.
3. A review of the total numbers of hysterectomies performed (Table 2) indicates a continuing decline. This is apparent in a comparison of the number performed one year prior to the study with the quarters prior to and after our study. It should be noted, however, that the percentage of hysterectomies performed on women age 30 and under remains consistently in the 25% range.
4. Although the study questions were broad, critical questions were those that indicated pathology, abnormal tissue, findings equivocal or suggestive of malignancy, and uterine prolapse. Dysmenorrhea, dyspareunia, pelvic pain, and abnormal bleeding alone were not considered absolute indications for hysterectomy in this evaluation of the data.

There were 634 hysterectomies performed in the study, (December 1975-February 1976). Of this total number, 472 were over age 30 and 162 were under age 30. In the over-30 group, 420 cases clearly met the critical criteria, for an acceptable rate of 88.9%. Of the 52 cases (11.1%) that did not fully meet these criteria, bleeding and other medical reasons were stated as the indication for the procedure. Only 25 cases (5.3%) in this over-30 group did not have clearly documented pathology, prolapse, or abnormal bleeding.

5. A seemingly high proportion (25.5%) of the hysterectomies in this study were per-

## AGE DISTRIBUTION OF HYSTERECTOMY PATIENTS



formed on women under 30. This percentage was fairly constant in like time periods prior and subsequent to our study (Table 2). Twenty-six of the 162 cases under age 30 lacked information or contained conflicting data. In these 26 cases, it was necessary to go back to the patient records for additional information. When this data was gathered, it was found that 7 cases did not fully meet the critical criteria—a rate of 4.32% in the under-30 group. Of these 7 cases, 3 had documented bleeding problems and 2 had given persistent pain as the medical reason for surgery. Finally, one case had too little data on the record to allow a clinical conclusion to be drawn, and one case had no clear indication for the procedure on the record. These two cases without indications represent 1.23% of the under-30 group.

6. A frequent occurrence was that of previous tubal ligation in the younger age group with hysterectomies and may represent an entity that could be named the "post tubal ligation syndrome".

### Post Tubal Ligation Syndrome

Although a rather extensive search of recent literature revealed very little in specific references to this syndrome, several investigators did report symptoms and problems that were encountered after tubal ligations. The incidence of reported post tubal ligation problems was exceedingly broad—from almost none (Lu and Chin)<sup>1</sup> to a

25% incidence of problems severe enough to require hysterectomy (Ringrose).<sup>2</sup> In a long term study of 1,055 cases of puerperal tubal sterilization performed in Hong Kong from 1957 to 1962, Lu and Chin noted the following problems during a follow-up period varying from 3-5 years.

**Pelvic Pathology**—At follow-up examination hydrosalpinx or peritubal adhesion was suspected in 5.9% of patients because of clinical evidence of thickening and small tender masses with slight fixation. None of these required operative treatment.

**Menorrhagia**—Some menstrual changes were noted in 51.8% of patients involving either length of cycle, duration of flow, or amount of blood loss. However, most of these changes were of a mild degree. Menorrhagia of such severity to require hysterectomy was observed in only four patients.

In 1974, Ringrose reported an incidence of 25% of patient post tubal ligation that required hysterectomy because of pelvic pain and menorrhagia following surgical tubal ligation. From his study of these cases, he postulated that the pelvic pain after surgical tubal ligation was caused by an interference with the physical dynamics of the adnexa that allowed torsion of the fimbriated end of the tube and the ovary that produced episodes of pain. He further suggested that interruption of the vascular network between the hormone producing ovary and the end organ uterus

was the causative factor for the menorrhagia.

Harris<sup>3</sup> in the CMA Journal in 1974, reported a tubal ovarian abscess as a complication of laparoscopic tubal coagulation. This case was also characterized clinically by menorrhagia and pelvic pain. Histologic examination confirmed the diagnosis of tubal ovarian abscess. He also reported on two cases in a series of 1,800 coagulations by Badra, *et al.* In these rare cases a tubal ovarian abscess also existed.

In another report, E. E. Rawlings<sup>6</sup> reported a very low complication rate for tubal ligation (9.6 total complication rate) and on none of these was a hysterectomy performed.

### Summary: Post Tubal Ligation Syndrome

From this review of the literature, one must conclude that the post tubal ligation syndrome does exist. The syndrome is characterized by pelvic pain and menorrhagia. It is probably caused by an interruption in the communicating vascular network between the hormone producing ovary and the end organ uterus. This disruption in the communicating links occurs surgically and is further complicated by repeated infection. The pelvic pain is probably produced by interference with the physical dynamics of the adnexa causing torsion of the tube and/or ovary. Again, recurrent infections with additional adhesions would amplify this process.

TABLE 2  
Percentage Age Distribution  
of Hysterectomy Patients

AGE IN YEARS	HASP	HASP	HASP	HASP	PAS
	12/74-2/75	9/75-11/75	12/75-2/76 (Study Period)	3/76-5/76	60, 62, 64
11-15	.01	.00	.002	.00	
16-20	.02	.02	.01	.01	
21-25	.11	.10	.10	.10	.01
26-30	.19	.18	.18	.18	.07
31-35	.20	.18	.21	.19	.11
36-40	.17	.18	.18	.19	.18
41-45	.12	.13	.13	.13	.22
46-50	.09	.10	.08	.09	.17
51-55	.05	.04	.04	.05	.12
56-60	.01	.02	.01	.02	.08
(1) Total No. of hysterectomies performed	786	739	634	616	
(2) Total No. of hysterectomies performed on women under 30	168	183	162	155	
(3) % of hysterec- tomies performed on women age 30 and under	21.3	24.7	25.5	25.1	



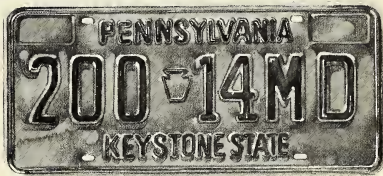
Examination of the cases included in this MCE study reveals that of the 162 cases in this series of hysterectomies performed on women under 30, six had symptoms of pelvic pain and menorrhagia following tubal ligation. All six of these exhibited pathological findings of chronic salpingitis with tubal ovarian adhesions and evidence of pelvic inflammatory disease. The tubal ligations in these six cases had been performed from one to four years prior to the hysterectomy. All had a clinical history of polyhypermenorrhea. One might conjecture that the repeated infections that were common in the clinical history of all six might have contributed to the pelvic pain component of the syndrome and perhaps to the menorrhagia.

### Conclusions

1. MCE studies on a regional or statewide basis can be more efficiently and accurately performed retrospectively utilizing a small, well-trained staff of auditors.
2. This MCE study showed a pattern of care consistent with previous patterns of care in age distribution. Criteria for hysterectomy may be present, (or perhaps is being discovered), at an earlier age.
3. The percentage of women under 30 on whom hysterectomies were performed in this study seems to be consistent and at the same level with periods of time prior to and after the study.
4. An exceedingly small percentage of those cases studied did not have appropriate indications for hysterectomy by the criteria denoted.
5. The "post tubal ligation syndrome" was discussed, with a review of the existing literature of cases in this study which were evaluated and could be categorized as "post tubal ligation syndrome." ◀

### References

1. Reid, D. E.: "Controversy in Obstetrics and Gynecology II, 1974," *Preferable Methods of Conception Control*.
2. Ringrose, C. A. Douglas: "Post Tubal Ligation Menorrhagia and Pelvic Pain," *Int. J. Fertil.* 19:168-170, 1974.
3. Harris, W. H.: "Tubo-ovarian Abscess following Laparoscopic Tubal Coagulation," *CMA Journal*, December 7, 1974, Vol. 111.
4. Wheelless, C. R.: "Review of 3,600 cases," *Obstet. Gynecol.* 42:751, 1973.
5. Badra, P. L., Young, J. R., Laros, R. K., et al.: "Suppurative Salpingitis After Laparoscopic Tubal Cauterization," *Ibid* p. 511.
6. Rawlings, E. E., Bostock, J.: "Complications of Laparoscopy," *Br. Med. J.* 1:727, 1975.



### HOW TO HEAVY UP ON A LIGHTWEIGHT BUDGET:

Nearly 40% of all U.S. physicians read N.Y., N.J., Pa., Ill. or Ohio State Journals. Heavy up where it counts! 80,000 plus M.D.'s for \$1330 per highly-read page. Talk to Karl Messerrry, (203) 661-9702, United Media Associates, Inc., 16 Bruce Park, Greenwich, Conn. 06830, representing

### THE KEY STATE JOURNALS



# Night Calls in Family Practice

B. W. McGUINNESS, M.D./MERSEYSIDE, ENGLAND

*A recent study by the American Medical Association found that more than 17 million physician house calls are made in the United States each year. This figure indicates that about two percent of all physician services are now delivered at home.*

*The study also noted that income level was a relatively insignificant factor. About 40% of the house calls concerned patients with an annual family income under \$5,000. Twenty percent were noted in the \$5,000 to \$10,000 bracket, and the remaining 40% were from families earning \$10,000 or more annually.*

*Elderly patients, those 65 or older, accounted for 51% of all house calls in the study. Patients in the 45 to 65 age range accounted for the second largest proportion, 25% of the calls.*

*Finally, 56% of the calls were for disabled patients. The majority (70%) of calls were made in large cities, and 62% of the total concerned female patients.*

*Dr. McGuinness' article addresses the incidence and nature of house calls made in Great Britain.*

British family physicians are required to visit their patients at home whenever the clinical condition warrants it. In practice this means that patients have the right to demand the doctor's attention more or less at will, although theoretically it is the physician who makes the decision as to whether a house call is necessary. Recently the necessity for night calls to the home has been challenged (B.M.A. News 1975) and it has been stated that "most of the much publicized night work merely satisfies the doctor's delusions of grandeur and could be withdrawn permanently without serious loss."

There is, however, a contrary viewpoint and Lockstone, writing about his own group practice in Yorkshire, defended the notion that there is still an important place for house calls at night despite the fact that only half of all the night visits in his series were genuine emergencies. Since there was so little up-to-date information in the literature on the subject of night calls, I examined my records for all night calls for every year from 1971 to the summer of 1975.

In August of 1975 I left Britain to take up an academic appointment in Illinois after having

been a full time National Health Service general practitioner for twelve years.

## Methods

### *Aims and Practice Profile*

My records are complete for all night work from 1971 onwards and from examination of them it has been possible to determine the incidence of night calls and also to assess the urgency and severity of the conditions generating the work.

The practice was situated in a small south Shropshire market town not far from the border between England and Wales. It was made up of six doctors and one trainee (resident) for most of the time described and there was a combined practice list of between 14,000 and 14,500 patients. The community is supported by mixed farming and light industry including a carpet factory, a glove factory and an aluminium products company. In the newer parts of the town there is a tendency for the men to commute to other larger towns to work and a small mobile population of service families is also cared for at a nearby small Royal Air Force camp. Seventy-five percent of the practice is urban and twenty-five percent rural.

In addition to the routine work of family practice, the partners are also responsible for staffing a small acute hospital of about 58 beds, 16 of these designated general practitioner beds, the area's casualty department and a general practitioner maternity unit in the same building. The nearest district general hospital is at Wolverhampton, 14 miles away. Virtually all the



BRIAN WILLIAM McGUINNESS, M.D., an associate professor in family medicine, is currently academic sub-dean at the University of Liverpool, England. At this writing, Dr. McGuinness was affiliated with the Southern Illinois University School of Medicine family practice department in Springfield. He is a member of the American Academy of Family Physicians as well as a Fellow of the Royal College of General Practitioners.

practice obstetrics is conducted in the general practitioner unit so there are no maternity calls in this series and calls to hospital or casualty department also are excluded.

There was no deputy service available in the area and all the calls in this account were made by myself. Telephone conversations, usually requests for advice, were not recorded and all the home visits described were initiated by or on behalf of the patients.

All housecalls attended between 23:00 hours (11:00 p.m.) and 07:30 hours (7:30 a.m.) the next morning were recorded in my diary, but since my partners did not note their work pattern, it has not been possible to make a study of the characteristics of the practice night work as a whole. Calls to the home were recorded by diagnosis and classified into one of the three groups according to my assessment of urgency:

#### *Group I Medical Emergencies ("Genuine" Calls)*

Defined as a serious condition clearly needing urgent treatment either to save life, prevent further unacceptable and potentially serious deterioration, or alleviate severe pain or distress. Patients found to be dead on my arrival or who died during emergency treatment are also included in this group.

#### *Group II Irresponsible Calls.*

No treatment was given to patients in this group although no opportunity for delivering a personal dose of patient education on the theme of social responsibility was lost.

#### *Group III Medically Unnecessary But 'Reasonable' Calls.*

In this group were placed calls that I felt, after listening to the story and examining the patient, could not be said to involve a genuine medical emergency, did not involve the possibility of deterioration nor the danger of death without instant treatment, but nevertheless did raise a problem needing a doctor's help. A fairly generous margin for doubt was allowed in this group and cognizance of the patient's intelligence and his family's understanding was taken before a classification of any call was made.

### **Results**

The total number of night calls personally attended between January 1, 1971 and July 1, 1975 was 79 (average 18 per year). Multiplied by the number of partners this gives an average annual

figure of 108 for the practice as a whole or approximately 13 calls per 1000 patients per year.

Group 1 Emergencies	32 (40.5%)
Group 2 Irresponsible Calls	16 (20.25%)
Group 3 Unnecessary but Reasonable Calls	31 (39.25%)

---

#### Group 1: Analysis of the emergencies

(a) Medical causes	18
(b) Surgical & gynecological causes	8
Dead	6
Total	32

A total of 12 were admitted to hospital, 6 of these treated personally in the general practitioners' beds.

(a) Medical causes	
Myocardial infarction	4
Pneumonia & heart failure	3
Pyelitis	1
Pneumonia (infant)	1
Asthmatic bronchitis	2
Acute L.V.F.	2
Asthma	4
Epilepsy	1
Total	18

(b) Surgical causes	
Abortion	2
Acute Appendicitis	2
Renal colic	1
Fractured femur	1
Gallbladder colic (chole lithiasis)	1
Acute urinary retention	1
Dead on arrival or dead under treatment:	6
Total	8

---

#### Group 2 Analysis of the unnecessary or irresponsible calls

- 1 Hysterical behavior in psychopath after family quarrel
- 3 Sore throat of a few hours duration
- 2 Mild tonsillitis of two days duration
- 1 Nothing (call made by relative without patient consent for a mild giddy spell). Nothing found.
- 1 Slightly bruised leg over varicose vein (had been out for the day)
- 1 Drunk
- 1 Indigestion and anxiety because husband going away for the day.

- 1 Dysmenorrhea for a few hours (watching TV when visited).
  - 1 Indigestion due to a hiatus hernia of many years standing.
  - 1 Rubella (saw another doctor earlier in the day).
  - 1 Vomited once after fatty meal. Nothing found on examination.
  - 1 "Tiredness all the time." (Call made by a friend without patient consent).
  - 1 Mild upper respiratory infection
- 16 Total

---

Group 3 Analysis of calls considered unnecessary, but reasonable

- 1 Fainting (vaso-vagal)
- 1 Whooping cough
- 1 Angina
- 5 Childhood croup
- 2 Chronic gallbladder disease
- 2 Mild bronchitis
- 4 Psychiatric problems
- 2 Degenerative heart disease plus social problems
- 1 Migraine
- 3 Otitis media
- 1 Herpes Zoster
- 1 Bartholin's disease
- 1 Influenza
- 2 Bronchiectasis
- 1 Bronchial carcinoma
- 1 Pyelitis
- 1 Diabetic with upper respiratory infection
- 1 Fell downstairs while drunk; cut head

31 Total

None of these patients needed admitting to hospital.

### Discussion

This personal study shows that less than half of all house calls attended at night, between 23:00 hours and 07:30 hrs, from the beginning of 1971 to the middle of 1975, were "genuine" emergencies. There was a relatively high rate of irresponsible calls where the visit was unnecessary on any grounds and the figure of 20% contrasts with the much lower 7% recorded by Lockstone during 1974. A smaller proportion of "unnecessary" but reasonable calls were found than in Lockstone's practice in Yorkshire and this different overall pattern may perhaps be ascribed to differences in local habits and customs. It is interesting that the West Midlands has a tradi-

tionally high rate of usage of medical services, second only to industrial South Wales in terms of demand rate on the general practitioner's resources.

One cannot but agree with the view that patients cannot be expected to possess medical knowledge sufficient to make their own diagnoses and I have every sympathy with the anxious parent or puzzled spouse who needs help in interpreting a symptom or organizing simple home nursing. However the figure of 20% unnecessary and irresponsible calls is too high to be passed over lightly, still less indulgently. Medical skills are scarce and the emotional demands upon any conscientious practitioner are heavy enough without an additional load being applied by the selfish and the silly.

On the positive side there is the definite boon to the patient of having a physician at his bedside, which must be a great comfort during the dark hours when fear and loneliness are added to the pain and anxiety of sudden illness. Society as a whole benefits on a more material plane when one considers, as was pointed out by Lockstone, that the alternative to a doctor's night visit is usually an expensive and perhaps hazardous trip to hospital in an emergency ambulance. In my own series only twelve patients needed hospital admission and of these I was able to look after six myself in the general practitioner beds of our local hospital.

Night services are evolving and doctors are turning increasingly to deputization services or at least rota arrangements with colleagues. Both solutions are open to a certain amount of valid criticism. Often the stand-in doctor has no knowledge of the patient, no access to the previous medical records and no training in or experience of the home management of illness.

It is my belief that disillusionment with a community ethic that is prepared to accept a high rate of frivolous or thoughtless use of doctors' time during the night is one of the prime reasons why criticism of this aspect of current medical services has risen to present levels. To admonish doctors to be "responsible" and "dedicated" is unlikely to produce a favorable response unless one can match such well-meaning exhortation with action to curtail minority abuse of those same doctors by reeducation of the public in social responsibility. ◀

### References

1. B.M.A. News (1975).
2. Lockstone, D. R. *Journal of the Royal College of General Practitioners*, 26, 68-71 (1976).

# Doctor's News

**NEW MEDICAL EXAMINING COMMITTEE**—Joan Anderson, director-designate for the Ill. Dept. of Registration and Education, has appointed a new Medical Examining Committee. The appointees are: Doctors David S. Fox, and Richard Rovner, chairman, both of Chicago, Robert Behmer, M.D., Rockford and Charles Bobelis, M.D., Dundee. Reappointed were Doctor Mays Maxwell of East St. Louis, Dale Richardson, a Pontiac osteopath and Paul Tullio, a Glen Ellyn chiropractor.

**COUNTER MOVES UPDATE**—The appeal of the jury finding for Leonard Berlin, M.D., in his successful countersuit, is going up. The defendant attorneys are in the process of preparing briefs and Dr. Berlin has filed a cross appeal. Similarly, the finding for the defendant attorney in the countersuit by Drs. Eugene Balthazar and Frederick Schoenfeld is being appealed. The appeal on the pre-trial ruling against Drs. Anton Pantone and Arnold Swerdlow has been filed.

Meanwhile, Dr. Donald W. Lyddon, Sr., of Rockford, saw his claim upheld in pre-trial hearings when a motion to dismiss his allegations was denied. No trial date is known as yet. Another seven ISMS members have entered suits, or included a cross complaint in an answer. Another two are pursuing actions with the Attorney Registration and Discipline Commission, while Section 41 is being invoked in at least two other cases.

Recent actions in other states reflect an \$85,000 award (\$35,000 compensatory, \$50,000 punitive) to a Reno physician by a jury, and a \$109,700 default judgment in a case brought by a physician in Butte, Montana. An Oregon suit is presently on appeal before the Oregon Supreme Court.

The Task Force Committee on Moves to Counter Litigation is continuing to monitor cases in development of a national repository of data, and to pursue research materials on actions and points of law.

**ILLINOIS PHYSICIANS VOLUNTEER FOR IDMHDD FACILITIES**—More than 200 Illinois physicians volunteered to serve in Illinois Department of Mental Health and Developmental Disabilities (IDMHDD) facilities after the Department's 160 limited-license physicians were suspended in early March. The "permit physicians" were reinstated three weeks later under special legislation requiring them to be fully-licensed by March 1, 1978. The volunteer recruitment effort was spearheaded by Drs. Joseph Skom, ISMS President, Herschel Browns, M.D., CMS President and Alex J. Spadoni, President, Illinois Psychiatric Society (IPS).

The limited-license physicians, who represent half of the full-time medical staff employed by IDMHDD, have been practicing medicine under a 25-year-old policy with special certificates restricting their practice to state facilities. Legislation passed in 1972, however, required them to become fully-licensed by 1976. Some 127 permit-physicians failed a special examination given last December; the remaining 33 physicians did not take the test.

Doctors Skom, Browns and Spadoni, along with Robert deVito, IDMHDD Director, will serve on a special task force appointed by Governor James Thompson. The task force has been charged with developing means to eliminate the permit system by next March and attracting full-licensed physicians to the state hospital system.



**PHYSICIANS IN THE NEWS**—**Fredric D. Lake, M.D.**, Evanston, has been elected president of the American College of Radiology. Dr. Lake, an ISMS past president, is currently director of the department of radiology at Columbus Hospital in Chicago and chairman of the board of chancellors for the ACR. The founding president of the Illinois Chapter of ACR (1965) is also a member of the Illinois State Advisory Hospital Council and chairman of the ISMS Task Force on Professional Liability. . . . The College also announced that four Illinois radiologists have been cited for distinguished medical achievements and named as fellows of the association. **Leonid Calenoff, M.D.**, Chicago, **Galdino Valvassori, M.D.**, Winnetka, **Peter E. Weinberg, M.D.**, Chicago and **Richard G. Wilson, M.D.**, Rockford, have joined the distinguished group.

The Illinois Psychiatric Society has announced its new officers for 1977-78. **Roy R. Grinker, Sr., M.D.**, Chicago, will serve as the society's president. Dr. Grinker recently retired from chairmanship of the department of psychiatry at Michael Reese Hospital, where he had practiced for over 50 years. The new IPS president-elect is **Jerome S. Beigler, M.D.**, Chicago, and **Dr. Robert Nunn**, Glencoe, will service as secretary. **Robert DeVito, M.D.**, Downers Grove, director of the Illinois Department of Mental Health and Developmental Disabilities, will maintain his post as treasurer.

**Philip L. White**, Wilmette, AMA director of the department of foods and nutrition, has been awarded the Conrad A. Elvehjem Award for public service by the American Institute of Nutrition. In announcing the award, the Institute noted Dr. White's outstanding contribution in education related to foods and health. The Ernst Jung Price for Medicine has been awarded to **Georg F. Springer, M.D.**, Evanston, director of the department of immunochemistry research at Evanston Hospital. Dr. Springer's award cited "extraordinary achievements on immunobiological aspects of early diagnosis and therapy of human breast carcinoma." His research has concerned an immunological basis for breast cancer. Tentative findings have demonstrated that when a certain red cell antibody is severely depressed, there is an 85% chance that the person will have breast cancer. Dr. Springer will share the award with a California physician. **Edward John McCarron, M.D.**, Chicago, has been elected president of the Illinois Society of Physical Medicine and Rehabilitation. Dr. McCarron serves on the staff of Northwestern Memorial Hospital.

Several hospitals have announced changes in their medical staffs. **Irvin Strub, M.D.**, Lincolnwood, was elected president of the medical and scientific staff-faculty at Mercy Hospital and Medical Center in Chicago. Also at Mercy, **Morris Proffitt, M.D.**, Chicago, will be senior vice-president and **John Picken, M.D.**, Chicago, secretary-treasurer. **Nelson D. Sanchez, M.D.**, Western Springs, was named medical director of the St. Mary of Nazareth Mental Health Center. Dr. Sanchez has worked in several psychiatric positions at St. Mary's, including the deputy directorship.

**POPULATION EXPLOSION**—The AMA has estimated that the U.S. physician population has grown at roughly twice the rate of the American community over the past fifty years. Since 1970 that rate has more than doubled. Attributing the growth to increasing numbers of medical schools and also foreign-trained physicians, the AMA noted that an HEW projection has placed the population-per-doctor ratio at 1/490 persons.



## Who Are 'Those Guys'?

Government gradually has tightened its grip on the medical profession. Its carefully-plotted approach now has brought the bureaucracy within sight of its goal: total control. How did government manage to reach this point? Generally, physicians can't supply a detailed answer, but they know who to blame: "Those guys (leaders of organized medicine) let it happen."

Most physicians suffer from a contagious disease called "pass-the-buck syndrome." Symptoms include chronic complaining and a tendency to blame their county medical society, ISMS and the AMA for not adequately defending the profession.

However, blaming organized medicine is the easy way out. As your president, I now qualify as one of "those guys," but my definition of the term differs from the standard version. I include you, the members.

Halting government intervention demands the greatest effort ever undertaken by organized medicine. Without your active participation, that effort is doomed to failure. I pledge to wage a vigorous fight to preserve the freedom of our profession. I ask your support.

A handwritten signature in cursive script that reads "George T. Wilkins, Jr." The signature is written in dark ink and is positioned above the printed name.

George T. Wilkins, Jr., M.D.

## Illinois Mental Health Code Proposals and Problems

THOMAS T. TOURLENTES, M.D., ILLINOIS STATE MEDICAL SOCIETY/ILLINOIS  
PSYCHIATRIC SOCIETY TASK FORCE ON THE REVISED MENTAL HEALTH CODE

Many physicians are disturbed by legislative proposals emanating from the Governor's Commission to Revise the Illinois Mental Health Code. The long-awaited report, produced after three years at a cost of \$300,000, would revise substantially the 1967 Mental Health Code. The Commission consistently has ignored the necessary balance between everyday clinical realities and legal theories. Its major preoccupation appears to have centered on "protecting" the individual by obstructing entry into the mental health care system. Underlying assumptions seem to be that the current mental health care system is predatory and only a legal adversary system can prevent patient abuse.

This development was predictable from the Commission's establishment in December, 1973. Casual review of Commission membership and staffing reveals that over half the active participants are attorneys. Mental health professionals in general, and psychiatrists in particular, constituted a distinct—though vocal—minority, but have had little influence on Commission dialogue.

After a long and detailed analysis of the Commission report, the ISMS/IPS Task Force on the Revised Mental Health Code recognizes that the report represents a great deal of dedicated work. Unfortunately, misguided priorities seem to prevail. The result is some distressing proposals which greatly overshadow the potentially positive features of the proposed legislation.

The ostensible purpose—to facilitate and upgrade clinical service to the mentally ill—is obscured by attitudes and procedures which repeatedly state that zealous advocates should closely monitor untrustworthy physicians. The proposed legislation would transform almost any therapeutic relationship and treatment process into a never-ending series of adversarial interactions and formal confrontations. Understandable and reassuring health care terminology is replaced by contrived and impersonal legalistic jargon. Patients are "respondents" or "recipients of treatment". Doctors are "providers" and equated with non-medical "qualified examiners". Hospitals

and clinics are interchangeable "facilities".

Constructive criticism is hampered by the extremely detailed, inflexible and heavily cross-referenced nature of the various proposals in the legislative package. A single change must be traced and reworked through multiple sections. Some proposals of intrinsic merit are incompatible with other suggested changes.

Three areas of particular concern to the Task Force include: (1) subordination of treatment needs to freedom rights; (2) distrust and extreme regulation of treatment methods; and (3) equation of civil commitment with the criminal process.

### Treatment Needs

The organizing principle for most Commission dialogue and decision-making apparently is the single legal issue of constitutional "freedom" rights. Few thoughtful people—least of all physicians—would disagree with the extreme importance of an individual's freedom. Freedom is precious and should never be abridged without good cause or relevant due process. However, for freedom to be meaningful, the individual: (1) must have some awareness of his various options (insights); and (2) must have some reasonable capacity to make adaptive changes (reality testing). Freedom to deny obvious reality, particularly when harm does result, is not a responsible application of the principle and should not be considered a constructive discharge of society's protective duties.

One Commission spokesman has proposed, because no *legally* satisfying definition of mental illness exists, that the *only* constitutional reason for depriving an individual of freedom is physical dangerousness or helplessness. Under this assumption, beneficial care and treatment must be denied to many seriously ill people who do not have the awareness to act prudently on their own behalf. Lack of insight is a primary symptom of many forms of serious mental illness. The community surely has an obligation to protect and help these people and not to encourage self-neglect and social isolation. This goes far beyond

the right to be "different" or simply non-conforming.

This naive notion of unfettered freedom serves no useful purpose. It is another word for social indifference and denial of community responsibility. We have a constitutional duty to provide equal and adequate protection (treatment) for all in need, not just for those who request it. Sick individuals should not be sacrificed to uphold abstract concepts of absolute freedom.

An analysis of the proposed requirement for involuntary commitment of minors reveals the Commission's inconsistency on the philosophical issue of liberty. Three requirements would have to be fulfilled for involuntary hospitalization of a child: (1) the presence of diagnosable symptoms of serious mental illness; (2) the availability of appropriate hospital resources; and (3) the prospect of some improvement with treatment. Since children are rarely psychotic, it seems cruel and discriminatory to offer less protection to countless adults suffering from more serious forms of mental illness.

Unnecessarily narrow requirements for involuntary commitment of adults can only result in effective punishment of seriously disturbed individuals by police who must file "disorderly conduct" charges. This occurs with increasing frequency in states with similar restrictive criteria for non-voluntary hospitalization. Hopefully, we will conclude wisely that the mentally ill of Illinois deserve something more charitable than jail when unable to cope with serious mental problems.

### Treatment Restrictions

The undue emphasis on freedom has taken another curious and self-defeating turn. Mental patients are to have the right to refuse "standard treatments". This means that patients who think we are trying to poison them can refuse medication which would remove their delusions. Deeply depressed individuals, who characteristically feel worthless and undeserving, also could refuse treatment which might improve mood and avert self-destructive behavior. This "right" puts patients who deny their illness in the anomalous position of dictating how they are to be treated. The only proposed remedy is adversarial litigation. Professional training, clinical experience and expert judgment are to be ignored under these circumstances.

This approach seems to presume that the mental health system is largely incompetent, unreliable and self-seeking, and that courts are more

likely to make benevolent decisions. In other words, courts are to have final authority regarding treatment, but hospitals are to have responsibility for results. Therapists will be held accountable in meticulous detail for all treatment plans and actions, but courts will be accountable to no one for possible perfunctory performance of related duties.

### Inappropriate Judicial Prerogative

It is further proposed that courts should have broad authority to order different or better services for patients who are dissatisfied with the existing mental health programs funded by the General Assembly. Constant chaos will result. It seems unlikely that 102 county courts can develop the expertise or interest to design better programs than full time mental health professionals. The whole state mental health services delivery system could be subject to constant legal harassment by demanding patients.

Under the proposed code, all patient-related incidents would be forwarded to an independent "Legal Advocacy Service" for investigation. The establishment of this service seems based on the assumption that medical, psychiatric and other clinical judgments about the mentally handicapped can be made equally well in most cases by attorneys. Legal Advocacy Service counsel, for example, are to play "indispensible roles in commitment proceedings in determining whether these respondents are *accurately diagnosed* as mentally ill or mentally retarded." The proposed Legal Advocacy Service also presents serious confidentiality-related issues. Although some of the services to be provided by this group are desirable, they could be performed equally well, more economically and with less danger of abuse of power, by creating a specific division within the existing state agencies.

Under the proposed code, clinical psychologists, social workers and psychiatric nurses would be permitted to participate in the commitment process. This proposal is an expedient one, justified largely on grounds that physicians are not always available to perform initial certifications. Unfortunately, the distribution of proposed substitutes tends to follow that of the scarce physicians, and this change would do little to resolve the problem of timely initial certification. It would appear that the proposal seeks to downgrade and perhaps eliminate any significant role for the physician. This arrangement, of course, recklessly discounts the need for medical training

(Continued on page 385)



# Hyperparathyroidism

## In a Patient with Thyroid Hemiagenesis

By ROBERT J. MAGANINI, M.D., F.A.C.S., AND K. NARENDRAN, M.D./HINSDALE AND HINES

Thyroid hemiagenesis is a rare anomaly with an incidence of about one in 1700 cases as detected by  $I^{131}$  scan. The hemiagenesis is usually left-sided.<sup>7</sup> The fact that various thyroid diseases have been associated with this anomaly is well appreciated. The incidence in patients without thyroid disease is not so clearly established since this group of patients is not frequently subjected to  $I^{131}$  uptake and scan. The diseases associated with hemiagenesis include carcinoma, Basedow's disease, Grave's disease and adenomatous goiter.<sup>5-7</sup> No other instance of hyperparathyroidism due to parathyroid adenoma in association with thyroid hemiagenesis has been reported in the literature.

The physician who sets out to explore the neck of a patient for parathyroid adenoma and who finds that his patient has thyroid hemiagenesis is likely to have several questions come to mind pre-operatively. (1) Will the parathyroid glands be in a normal location at the site of the hemiagenesis? (2) Will other structures such as the superior and inferior thyroid arteries and the recurrent laryngeal nerves be present in their normal locations at the site of the hemiagenesis? (3) Concerning the contralateral side, that is,

the side where the thyroid mass does exist, will the parathyroid and other structures be normal or will they be ectopic and possibly even intra-thyroidal?

### Case Report:

A 37-year-old white male was admitted to MacNeal Memorial Hospital with a history of passing ureteral calculi on several occasions during the eight months prior to admission. Patient was also found to have an elevated serum calcium and a low phosphorus by his attending physician on numerous occasions. After three days on a Bauer-Aub diet, the serum calcium was 5.8 mEq/l and the serum phosphorus was 2.0 mEq/l. The urinary calcium excretion for 24 hours was 450 mg, (normal 50-300 mg) and the urinary phosphorus excretion for 24 hours was 1092 mg, (normal 600-700 mg).

An  $I^{131}$  uptake and scan were done on the following day and the uptake was found to be within the euthyroid range at 14%. The scan, however, revealed the right lobe to be of normal size and contour with normal uniformity of function. There was no evidence of uptake over the left lobe and it was thought that the left lobe was congenitally absent. A TSH stimulation test was not done, but a repeat scan the next day was performed to assess the upper portions of the neck. No additional thyroid tissue was found at the base of the tongue or in the suprathyroid position. The conclusion of the radiologist was that the left thyroid lobe was congenitally absent.

### Surgical Exploration

Patient was taken to surgery for exploration of the neck for parathyroid adenoma. On the right side of the trachea we found an enlarged right thyroid lobe with a relatively normal configuration. The right superior parathyroid was exposed

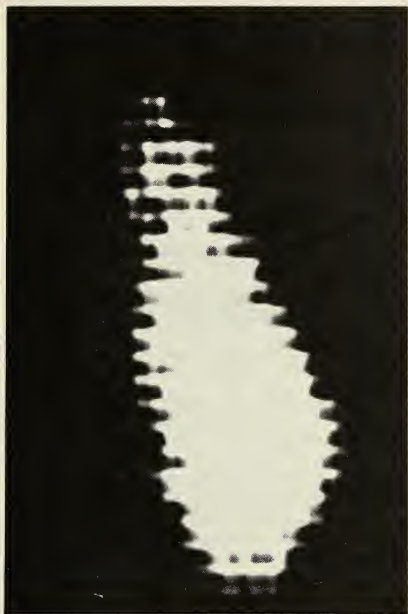
---

ROBERT J. MAGANINI, M.D., F.A.C.S., is a clinical assistant professor of surgery at the University of Illinois Abraham Lincoln School of Medicine. Dr. Maganini, a general surgeon, is also on the staff at MacNeal Memorial Hospital in Berwyn, Illinois.

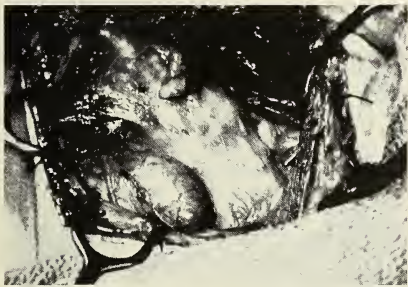


KUMARAPILLAI NARENDRAN, M.D., is currently engaged in a fellowship project in gastroenterology at the University of Louisville in Kentucky. He is affiliated with the Veterans Administration Hospital in Louisville. Dr. Narendran specializes in surgery and internal medicine. This article was written during his surgical residency at MacNeal Memorial Hospital.

first and was normal in size, location and appearance. A tedious dissection was then performed to locate the right inferior parathyroid. However, it was not found. The right superior and in-



**Figure 1**  
Reproduction of  $I^{131}$  Scan



RIGHT THYROID LOBE TRACHEA EMPTY LEFT FOSSA

**Figure 2**  
Photograph of Thyroid Exposure at Surgery and Explanatory Sketch.

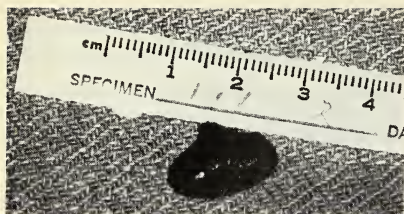
ferior thyroid arteries and the recurrent nerve on the right were found in the normal anatomical position.

We then proceeded to explore the left side of the neck where we found the superior and inferior thyroid arteries and the left recurrent nerve lying in the empty bed of the absent left thyroid lobe. Their anatomical positions were normal. In addition, the left superior parathyroid gland was found to be in the normal location and was normal in size and appearance. The left inferior parathyroid was then exposed in the areolar tissue just above and behind the sternoclavicular joint and it was found to be the site of a parathyroid adenoma approximately 1.5 cm in length. This parathyroid tumor was excised completely and histologic studies showed it to be an adenoma of the clear cell variety.

In addition to this, the lower pole of the right-sided thyroid mass was resected with the idea that the right inferior parathyroid gland could be intrathyroidal and could possibly be pathologic (since it was not found in the normal location). Later sections of this tissue revealed no parathyroid gland or adenoma and post-operatively the patient's metabolic aberration was corrected completely. The calcium and phosphorus reverted to normal and have remained so until this time.

### Summary

A case of hyperparathyroidism due to parathyroid adenoma in a patient with thyroid hemiagenesis is presented. Surgical exploration of this patient revealed normal anatomy of the recurrent laryngeal nerves as well as the superior and inferior thyroid arteries on both sides of the neck.



**Figure 3**  
**Photograph Parathyroid Adenoma**

On the side of the thyroid mass, only the superior parathyroid gland was found and the inferior gland was not found in the normal location nor was it intrathyroidal (lower pole resected). This infers that the right inferior parathyroid was either ectopic or congenitally absent.

In 13.1% of cases, only 3 parathyroid glands are found.<sup>1-3</sup> On the side of the thyroid agenesis a normal superior parathyroid gland was found and an adenoma of the inferior parathyroid gland. Resection of the parathyroid adenoma in

the inferior position was performed and resection of the right lower pole of the thyroid mass. Post-operatively, all signs of hyperparathyroidism were permanently alleviated. The value of the  $I^{131}$  uptake and scan as a pre-operative investigation in cases of hyperparathyroidism is borne out by this case report. ◀

#### References

1. Gilmour, J. R.: "The Embryology of the Parathyroid Glands, the Thymus and Certain Associated Rudiments," *Journ. Path.* 1937, Vol. 45, p. 507.
2. Gilmour, J. R.: "The Weight of the Parathyroid Glands," *Journ. Path. Bact.*, 1937, Vol. 44, p. 431.
3. Gilmour, J. R.: "The Gross Anatomy of the Parathyroid Glands," *Journ Path. Bact.*, 1938, Vol. 46, p. 133.
4. Golinger, R. C.: "Thyroid Hemigenesis with Goiter," *JAMA*, 1973, Vol. 224, p. 128.
5. Hamburger, J. I. and Hamburger, S. W.: "Thyroidal Hemigenesis," *Arch. Surg.*, March, 1970, Vol. 100, pp. 319-320.
6. Harada, T., Nishikawa, Y. and Ito, K.: "Aplasia of One Thyroid Lobe," *Am. Journ. Surg.*, 1972, Vol. 124, pp. 617-619.
7. Rusotto, J. A. and Boyar, Robert M.: "Thyroid Hemigenesis," *Journ. Nuclear Med.*, Vol. 12, #4. pp. 186-187.

## LOW-COST GROUP INSURANCE ANOTHER ISMS MEMBERSHIP PRIVILEGE

FOR INFORMATION,  
ASSISTANCE  
& DETAILS CONTACT:

Administrators:

**PARKER, A. V. SHIRE & COMPANY**  
INSURANCE  
ESTABLISHED 1901

**THE GROUP DISABILITY PLAN** ● Provides up to \$1,732.00 monthly in the event of disability caused by Accident or Sickness. ● Special Guaranteed renewal feature. ● Protect your income and security.

**BUSINESS OVERHEAD EXPENSE PLAN** ● Pays your office overhead expense when disability strikes. ● Premiums are Tax Deductible. ● Pays in Addition to the Disability Plan Benefits.

**THE BASIC MAJOR MEDICAL EXPENSE PLAN** ● In or out of Hospital Benefits up to \$25,000.00 per Disability. ● Up to \$100.00 Daily Hospital Room and Board maximum. ● Subject to choice of deductible and 80% coinsurance.

**EXCESS MAJOR MEDICAL PLAN** ● Provides up to \$250,000 for Medical Expenses. ● Supplements any Basic Major Medical Plan and has a \$25,000 deductible. ● Low group rates. ● Truly catastrophic coverage.

9933 N. Lawler Avenue  
Skokie, Illinois 60076  
Phone: 312-679-1000

## Pediatric Preplexities

Ruth A. Seeler, M.D., Editor

# Value of Bone Roentgenograms in Diagnosis

## Congenital Syphilis with Unusual Clinical Presentations

BY VIVIAN J. HARRIS, M.D., CARLOS A. JIMENEZ, M.D. AND  
DHARMAPURI VIDYASAGAR, M.D./CHICAGO

*Research for this article was conducted in cooperation with the Departments of Pediatric Radiology and Pediatrics, Cook County Children's Hospital, University of Illinois, Abraham Lincoln School of Medicine and the Hektoen Institute for Medical Research.*

*Four infants with unusual presenting signs of congenital syphilis are reported. Initial diagnosis included congestive heart failure, anemia with solitary bone defect, battered child syndrome and prenatal osteomyelitis. Bone roentgenograms in each case indicated the presence of congenital syphilis. Bone films may suggest the diagnosis when clinical features are misleading.*

Although prenatal screening of pregnant women for syphilis has markedly reduced the incidence of congenital lues, the disease has by no means been eradicated. We have recently diagnosed 4 cases of congenital lues in infants ad-

mitted with another diagnosis: congestive heart failure, battered child, anemia with solitary bone defect and neonatal osteomyelitis. In each case the correct diagnosis was made from bone roentgenograms. Congenital lues may be part of the diagnosis in any sick infant.

### Case 1

A 6-week-old black male infant was admitted with dyspnea and epistaxis. He was born at term, following an apparently uncomplicated pregnancy and delivery. Dyspnea began at five weeks of age and became progressively worse. Height and weight were below the tenth percentile. The infant was pale, with intercostal and subcostal retractions and flaring of the ala nae. A grade II/VI systolic murmur was heard over the precordium with a gallop rhythm. The liver was palpable 4 cm and the spleen 1 cm below the respective costal margin. Pitting edema was noted over the hands and feet. Hemoglobin was 6.4 gm/dl.

The diagnosis was congestive heart failure. A chest roentgenogram revealed a large heart with

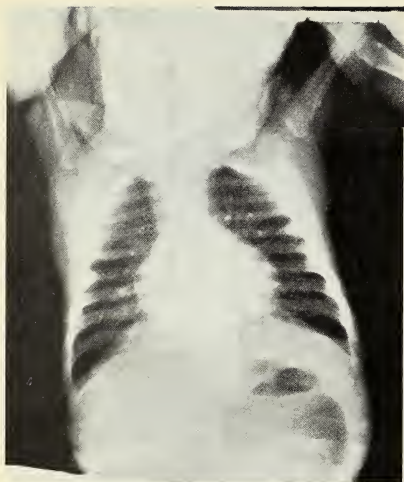
---

VIVIAN J. HARRIS, M.D., is director of the pediatric radiology department at Cook County Children's Hospital and a professor in radiology at the University of Illinois. Dr. Harris is an attending physician at the Loyola University College of Medicine and a lecturer at the Cook County Post Graduate School of Medicine and the Chicago Medical School.

DHARMAPURI VIDYASAGAR, M.D., director of the department of neonatology at the University of Illinois Hospital in Chicago, is an attending physician in pediatrics and former attendant in anesthesiology at Cook County Hospital. Dr. Vidyasagar is an assistant professor in pediatrics at the Abraham Lincoln School of Medicine, University of Illinois Hospital.

CARLOS A. JIMENEZ, M.D., is a fellow in nephrology at George Washington University Hospital in Washington, D.C. At this writing, Dr. Jimenez was a resident in neonatology at the University of Illinois Abraham Lincoln School of Medicine in Chicago.





**Figure 1**

Heart is large and there are congestive changes in the lungs. Periosteal thickening of several ribs and proximal humeri is seen.



**Figure 2**

Same patient as Figure 1. Prominent periosteal thickening seen along shafts of all long bones of lower extremities.

prominent lung markings but also periosteal new bone on several of the ribs and on the proximal area of the humerus. (Fig. 1) Additional films demonstrated thickened periosteal new bone in the extremities. (Fig. 2) Congenital lues was suggested and confirmed with RPR positive 1:512 dilutions and VDRL 1:512. After admission the child developed snuffles and a rash over his palms and soles.

## Case 2

A two-week-old infant was admitted because of anemia. Prenatal course was uneventful. The mother had noted a macular hypopigmented rash on the back and neck of the child at the time of discharge, which later spread over the child's body to include the hands and feet. The lesions included blisters, vesicles and wrinkled, peeled areas. The mother also noted coryza after hospital discharge. The infant was pale; his hemoglobin was 6.6gm/dl.

Roentgenograms revealed solitary abnormality of the right tibia with resorption of the cortex and erosion of the medial aspect of the sub-metaphyseal zone (Wimberger's sign). (Fig. 3) The diagnosis of congenital lues was confirmed by serological study.

The child was treated with procaine penicillin with healing of the skin lesions, correction of the anemia and healing of the tibial lesion.

## Case 3

A 6-week-old infant was admitted with deformity and swelling of the right arm. His 12-year-old brother had inadvertently sat on the baby's arm 3 days previously. Roentgenograms suggested multiple fractures, and the child was admitted as a possible battered child. The infant cried on passive motion of right arm. A fusiform swelling with erythema and tenderness was noted on left index and right fifth fingers and interpreted as dactylitis. There was no rash or snuffles.

Roentgenograms of the right arm on admission showed pathological fractures of ulnae and defective mineralization of distal diaphysis and metaphysis of all long bones. Additional films showed diffuse wide metaphyseal lucencies with disrupted trabecular pattern at metaphysis and

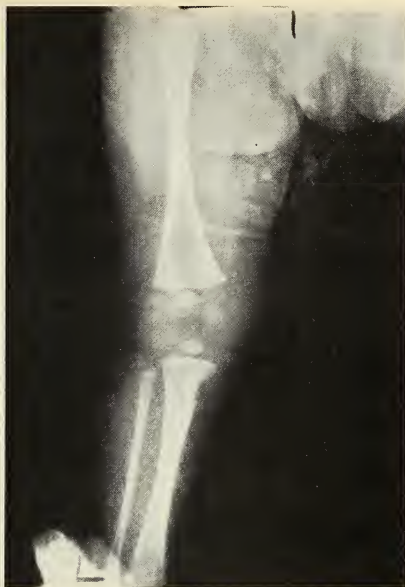


Figure 3

Submetaphyseal concave defect on medial aspect of tibia (Wimberger's sign) was sole bone lesion of patient #2.

periosteal new bone of the right humerus suggesting the presence of syphilis. (Fig. 4) There was a positive VDRL titer of 1:20 dilution, and VDRL of both parents was positive. Penicillin therapy, 50,000 units/kg/day administered for 10 days brought excellent recovery of movement of the right arm although the dactylitis persisted.

#### Case 4

A 2214 gram male was born to a 24-year-old mother at 36 weeks gestation.<sup>1</sup> At 8 hours of age examination revealed a swollen, tender crepitant left elbow and limited abduction of the left hip. Ortolani's sign was positive on the left.

Roentgenograms showed findings consistent with pyarthrosis of left elbow with periosteal elevation of distal end of left humerus and proximal radius and ulna. (Fig. 5) Bone destruction at these levels was also visible. The left hip was dislocated with evidence of destruction in proximal metaphysis and periosteal reaction. Diagnosis of congenital lues was considered by radiologist after review of films.

Prenatal osteomyelitis and septic hip was diagnosed clinically and a needle aspiration of both joints was performed at 30 hours of age. Thick yellow viscous fluid from left hip showed many polymorpholeucocytes, a few red cells and no bacteria on gram stain. One cc of blood-tinged fluid from left elbow yielded gram positive cocci and polymorphic cells on gram stain. Methicillin 200/mg/kg/day was then given intravenously as well as kanamycin 15 mg/kg/day given intramuscularly. Drainage of the left hip was performed at 2 days of age. Bacteriological examination of fluid obtained was negative, as was blood and cerebrospinal fluid. Cultures for toxoplasmosis, fungi and viral studies were also negative.<sup>1</sup>

By the 16th day of life, the baby's previously negative serological reaction became positive. Both parents had reactive tests for syphilis. Methicillin was discontinued and benzathine penicillin G was given intramuscularly. RPR was still reactive at 55 days of age.

#### Discussion

Syphilis was not considered in the original differential diagnosis of these infants. The roentgenographic appearance of the bones suggested the correct diagnosis. Both common radiographic



Figure 4

Pathological "V" shaped fracture extending from metaphyseal to diaphysis of proximal right ulna. Large metaphyseal zones of lucencies are also visible at distal humerus, distal radius and ulna.



Figure 5

Abundant periosteal newbone is seen about left humerus and ulna. Swelling about left elbow joint is present.

findings in unusual settings and uncommon findings were present. One of the misleading clinical presentations was heart failure secondary to anemia in an infant who also had periosteal thickening of ribs and long bones. This finding alerted both radiologist and clinician to the correct diagnosis.

Periosteal new bone formation occurs in syphilis as part of the polyostotic, symmetrical metaphysitis, diaphysitis and periostitis. Active infection beneath the periosteum produces a solid periosteal reaction.<sup>2</sup> However, differential diagnosis of periosteal reaction, including trauma, infantile cortical hyperostosis and normal variation,<sup>3,4</sup> also must be considered.

Since fractures are not a frequent occurrence in congenital lues, it explains why the presence of multiple fractures and elevated periosteum can suggest the "battered child." Metaphyseal location of fractures and symmetrical distribution in an infant raise the possibility of another diagnosis. Pathologic fractures in diaphyses are uncommon in lues and have been more frequently described in the metaphysis which shows altered mineralization and bone destruction.<sup>5</sup> This is a useful differentiating feature when trauma to an abused child is being considered.

Single bone lesions are unusual in congenital lues and might suggest other diseases. The one described, however, is typical of the destructive metaphysitis seen in congenital syphilis. Erosion of the proximal tibia medially (Wimberger's sign) is due to active syphilitic osteomyelitis which destroys both the cortex and marrow. It may be pathognomonic of syphilis.

The most unusual finding of all was the in-

stance of syphilitic arthritis, with involvement of a joint space and adjacent bony surfaces, in a newborn infant. Syphilitic arthritis was described in older children in 1886 (Clutton's joints) and in early 1900's by D'Arcy, Power and Axhauser,<sup>6,7</sup> who also found the highest incidence in older children. Cremin and Fisher recently added three additional juvenile arthropathies.<sup>4</sup> According to Axhauser there are two forms: synovial and osteal.

The synovial form, Clutton's joint, has only soft tissue swelling. The osteal form of arthritis has irregularity and erosion of the articular surface of adjacent bones, in the knee, tibia and femur. The destructive nature of the arthritis involving bones about the elbow and hip prompted the radiographic diagnosis of syphilitic joint involvement. One clinical feature of interest which added to the puzzlement of the case was the late onset of positive serology in the infant with syphilitic arthritis. Negative serologic tests in newborn do not necessarily exclude prenatal syphilis. This can occur if fetus is infected late in gestation so that positive serologic reactions may not appear until later time.<sup>7,8</sup>

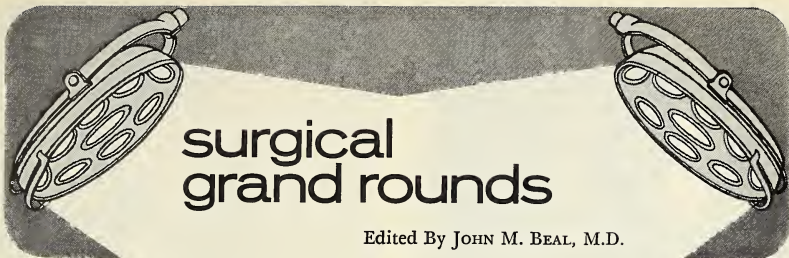
As exemplified with these patients, the characteristic findings that lead us to suspect congenital syphilis include failure to thrive, hepatosplenomegaly, rash, pseudoparalysis, jaundice, snuffles, edema and anemia.

In our series one or more symptoms was present in each instance although its significance was not initially suspected. ◀

## References

1. Harris, V. J., Jiminez, C. A., Vidyasagar, D.: "Radiological Quiz: Syphilitic Arthritis in a Newborn." *Radiology* (in press).
2. McLean, S.: "The Correlation of the Roentgenographic and Pathologic Aspects of Congenital Osseous Syphilis." *Am. J. Dis. of Child*, 41:363-95, 1931.
3. Coblentz, D. R., Cimini, R., Mikity, V. G. and Rosen, R.: "Roentgenographic Diagnosis of Congenital Syphilis in the Newborn." *JAMA*, 212:1061-44, 1970.
4. Cremin, B. J. and Fisher, R. M.: "The Lesions of Congenital Syphilis." *Br. J. Radiol.*, 43:333-341, 1970.
5. Fiser, R. H., Kaplan, J. and Holder, J. C.: "Congenital Syphilis Mimicking the Battered Child Syndrome." *Clin. Ped.*, 11:305-307, 1972.
6. Curtis, A. C. and Philpott, O. S.: "Prenatal Syphilis," *Med. Clin. North Am.*, 48:707-719, 1964.
7. Gray, M. S. and Philip, T.: "Syphilitic Arthritis, Diagnostic Problems with Special Reference to Congenital Syphilis." *Ann. Rheum. Dis.*, 22:19-25, 1965.
8. Saxoni, F., Lapatsanis, P., and Pantelakis, S. N.: "Congenital Syphilis: A Description of 18 Cases and Re-examination of an Old But Ever-present Disease." *Clin. Ped.*, 6:687-691, 1967.





*Surgical Grand Rounds are held weekly on Tuesday at 5:00 p.m. in the Offield Auditorium of the Passavant Pavilion of Northwestern Memorial Hospital. Patient presentations from Northwestern Memorial Hospital and the Veterans Administration Lakeside Hospital form the basis of the discussions. This case report was part of the Surgical Grand Rounds of September 28, 1976.*

## Case Report:

# Coarctation of the Aorta

**Dr. Marie Christensen:** A 20-year-old white man was in good health until two years ago, when on routine physical examination, he was noted to have a blood pressure of 190/120. He was treated with reserpine, 0.5 mg daily, which had no measurable effect on his hypertension. The patient specifically denied headaches, fatigue, shortness of breath, and chest pain. He did admit to occasional leg cramps associated with running and walking for a long distance, but was otherwise asymptomatic. He was referred to the Northwestern University Hypertension Clinic in July, 1976, because of poor control of the hypertension. At that time, he was found to have a blood pressure of 210/120 in both upper extremities and absent from lower extremity pulses. A presumptive diagnosis of coarctation of the aorta was made and he was admitted for aortography.

Admission physical examination revealed a healthy appearing, well developed man. His blood pressure was 170/110 in both arms; the chest was

clear; there was a Grade III/IV systolic murmur heard best at the apex without radiation. The only other pertinent physical findings were greatly diminished femoral pulses and no palpable popliteal, dorsalis pedis, or posterior tibial pulsations.

All routine laboratory examinations, including an electrocardiogram, were normal, with the exception of the chest roentgenogram.

**Dr. Leonid Calenoff:** Routine PA chest X-ray demonstrates bilateral rib-notching and a cardiac silhouette which is compatible with a modest degree of left ventricular hypertrophy. The deformed aortic knob and poststenotic dilatation which is sometimes seen on the plain chest X-ray was not present in this patient.

The thoracic aortogram revealed a somewhat dilated ascending aorta with narrowing throughout the transverse aortic arch. (Figure 1) There was complete obstruction at the level of the coarctation. The branches of the aortic arch were



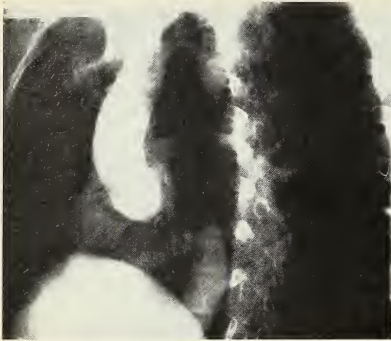


Figure 1

Thoracic aortogram demonstrated a somewhat dilated ascending aorta.

unusually prominent and the innominate and left subclavian arteries were larger than normal. These findings are better seen on a subtraction study, which demonstrates that the left subclavian artery is almost the same size as the mid-portion of the aortic arch. (Figure 2) Early films do not show any filling of the distal aorta. There are large collateral channels with exceptionally large internal mammary arteries. On a later film, we finally see the distal portion of the aorta as it is filled by posterior intercostal collateral arteries.

**Dr. Marie Christensen:** The patient was taken to the operating room for repair of the aortic coarctation which was performed through the left fourth intercostal space. At the time of operation, it was seen that the coarcted segment was approximately 1 cm in length with tubular narrowing above and below the area of complete obliteration. The left subclavian artery appeared to be larger than the distal aortic arch and the above-mentioned massive collaterals were present, both proximally and distally. The length of the coarctation, the disparity in size between the distal aortic arch and descending thoracic aorta distal to the coarctation, the large and numerous collateral vessels, and the tubular narrowing above and below the coarctation determined the treatment modality. It was decided to interpose a graft from the left subclavian artery to the descending thoracic aorta past the coarctation. This was accomplished with a preclotted 10 mm Dacron graft and partial occlusion clamps. The patient had an uneventful convalescence with the appearance of strong pulsations in the lower extremities. Postoperatively, he continued to man-

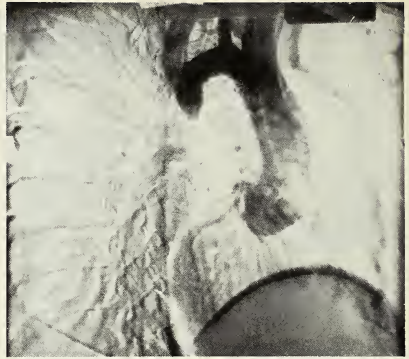


Figure 2

Subtraction study of thoracic aortogram reveals narrowing of transverse aortic arch, complete obstruction at the level of the coarctation and large collateral vessels.

ifest systolic and diastolic hypertension which was easily controlled with small doses of propranolol, chlorothiazide and reserpine. The patient was discharged on the eighth postoperative day and was seen six weeks later. He has remained normotensive and his antihypertensive medication is being gradually withdrawn.

#### Age Differential Considered

**Dr. Lawrence Michaelis:** This patient is presented to remind us that aortic coarctation is not limited to children and is still discovered with some frequency in adolescents and even in adults; to discuss the various operative procedures used for these patients (which are often different from the operation that is performed in young children with coarctation); and to point out that the hypertension associated with aortic coarctation is not always cured by operative repair.

It has been over 30 years since Crafoord in Sweden and Gross in Boston almost simultaneously first repaired aortic coarctation with resection and end-to-end anastomosis. This remains the standard technique for correction of the disease. There is still a mortality rate of 2 to 4% associated with the operation and a morbidity of about 10%. Most of the mortality and morbidity is associated with technical problems that develop in complicated and recurrent coarctation.

Coarctation of the aorta in adolescents and adults is often discovered in asymptomatic hyper-

tensive patients. These patients may never have had their blood pressure measured until they apply for employment or as part of a pre-high school or college physical examination. If hypertension has been previously noted, as was the case in today's patient, no one has examined the lower extremity pulses and so the diagnosis of aortic coarctation has not been made. When absent or diminished lower extremity pulses are discovered in hypertensive patients of this age group, aortography is indicated. This will reveal the presence of coarctation, the anatomy of the diseased segment, and the size and extent of collateral vessels.

Recurrent aortic coarctation is also present in this age group. This condition is being seen more frequently and is particularly bothersome to repair surgically. It usually occurs in young adults who have had their coarctation repaired in infancy. Recurrence is much more common when the repair is carried out in infancy (as high as 25%) because of the small vessel size. Another reason for recurrent coarctation is that the repair was formerly performed with silk suture, coated with wax or mineral oil. The suture acted as an irritant to the tissue and generated an intense

granulomatous reaction which, over the years, caused recurrent obstruction at the suture line.

Primary repair is now performed with very fine synthetic suture material. Interrupted suture technique is used for at least one-half of the anastomosis. Regardless of the operative technique, though, it seems unlikely that any suture line is capable of "growing with the patient", and I think the best that can be done is to resect all diseased tissue and keep inflammatory changes at the suture line to a minimum.

### **Complications in Repair of Recurrent Coarctation**

Recurrent coarctation is difficult to repair by another resection with end-to-end anastomosis. The tissue is friable and holds suture poorly. Dissection around the area of recurrence is difficult and it is easy to injure the recurrent laryngeal nerve. Also, mobilizing enough aorta proximally and distally to perform an end-to-end anastomosis without extensive suture line tension can be extremely difficult. Massive hemorrhage may occur with mobilization of these recurrent coarcted segments because of the friability of the large col-



**What the  
osteoarthritic  
patient  
perceives as  
"feeling better".**

Please see last page of advertisement  
for summary of prescribing information.

lateral vessels. The incidence of spinal cord damage thus increases because these collateral vessels often supply the thoracic cord.

Coarctation of the aorta may be associated with a long segment of coarctation or even a hypoplastic arch. In today's patient we were dealing with an arch which was moderately hypoplastic and a tapered aorta before and after the area of complete occlusion. There was enough discrepancy between the distal aortic arch and the descending thoracic aorta to make an end-to-end anastomosis technically difficult. These considerations plus the presence of the exceptionally large and numerous collaterals in the aorta which would have to be mobilized prompted us to perform a repair in this patient in which the coarcted segment was not resected and in which extensive mobilization was unnecessary. We simply performed a bypass graft from the large left subclavian artery to the descending thoracic aorta with partial occlusion clamps which promptly restored normal blood flow to the distal aorta. This type of operative repair is especially suited to these more complex situations.

The condition of absent collaterals should be mentioned briefly since it is often referred to in discussion of unusual types of aortic coarctation. Although the condition does occur, it is probably less frequent than some authors have suggested. When it does occur one is usually dealing with a pseudo-coarctation rather than a real coarctation because the absence of collaterals usually indicates adequate flow across the coarctation. However, there are instances in aortic narrowing without collaterals in which a significant gradient is recorded during exercise but none in the resting state.

### **Relatively New Bypass Procedure**

Until 30 years ago, surgeons hesitated in repairing aortic coarctation because it was not known that one could cross-clamp the aorta without damaging the distal organs. We now know that patients with coarctation have built-in protection because of the extensive collateral system. In fact, many patients have a completely obliterated lumen, and the aorta can be clamped above and below with no risk. In a situation where collaterals are absent, however, there is a real possibility of distal ischemic injury to the spinal cord, kidneys, or the gastrointestinal tract associated with long periods of aortic occlusion. In this situation some method of providing blood flow to the distal aorta during the repair must be employed. Alternatives include left heart bypass,

a temporary shunt from the ascending aorta to the descending aorta, or with the use of a permanent bypass graft inserted with partial occlusion clamps, thus never entirely obliterating aortic flow across the narrowed segment.

The operation which was performed on this patient and is suitable for all situations which have been described herein is the use of a graft to bypass the segment of coarctation. This operation is performed with a beveled, pre-clotted Dacron graft, 10 to 14 mm in diameter. Partial occlusion clamps are used to obviate the necessity of ligating collateral vessels and completely cross-clamping a non-occluded aorta. Use of a permanent bypass graft avoids systemic heparinization which is necessary in left heart bypass and in temporary shunting procedures. It also eliminates the need for extensive mobilization of proximal and distal segments which can be a problem in older patients, whose tissue is less elastic. The incidence of false aneurysm and suture line disruption is higher with an end-to-end anastomosis when there is tension on the suture line. Adequate mobilization with good apposition of the two segments without tension is obviously more difficult in older patients because the tissue is less elastic than in children.

A variant of the procedure done on this patient is used when there is significant hypoplasia of the entire aortic arch. This consists of a graft from the ascending to the descending thoracic aorta. This operation is done using two incisions. A lateral thoracotomy is first performed and the graft is sewn to the descending thoracic aorta just above the diaphragm and then tunneled beneath the hilum of the left lung. The patient is rotated, a median sternotomy is performed, and the graft is then attached to the side of the ascending aorta.

### **Post-Surgical Recovery**

In spite of adequate repair of the aorta, about one-third of the patients who undergo resection still have significant diastolic hypertension a year after the operation and many patients remain hypertensive permanently. Analysis of residual hypertension is complicated because 70% of patients with coarctation of the aorta have associated cardiovascular anomalies which may contribute to abnormalities of the blood pressure. A good rule of thumb is that the older the patient, the less likely is surgical hypertensive cure. It must be stressed that in older patients the hypertension does not go away immediately after repair. Occasionally a child literally wakes up nor-



motensive and remains so, but that is unusual. More often the hypertension gradually disappears over a two week to six month period. In some patients the hypertension is never completely relieved by operation, but even so, medical management of the residual hypertension is usually easier after repair. Today's patient was discharged on three antihypertensive drugs, and it will probably be six months before all of his medications can be stopped.

### **Aortic Coarctation and Hypertension**

One of the most interesting unanswered questions in coarctation of the aorta regards its relationship with hypertension. Dr. Kessler, who diagnosed the disease in this patient after he was referred to the Hypertension Clinic, will address this point.

**Dr. Richard Kessler:** I don't have the answer to Dr. Michaelis' question. Neither literature search nor clinical experience has supplied any answers.

Let me remind you that we need to distinguish between two elements. One is the systolic blood pressure and the other, the diastolic. One can

explain elevation of the systolic in the patient with coarctation on the basis of the loss of the "Windkessel" effect of the aorta. Remember that with the ejection of blood into the aorta, there is an expansion of the tissue of the walls of the great vessels which persists in providing a head of pressure throughout the period of diastole. In coarctation this buffering effect is lost and systolic pressure rises.

The presence of diastolic hypertension is a little more difficult to understand because one cannot evoke a reduced circulating arterial volume where adequate collaterals have been developed. The explanation for this remains unanswered.

### **Persistent Malady**

There are several extensive series in the surgical literature reporting on the persistence of hypertension, as Dr. Michaelis has said. There are those physiological areas where one could search for an explanation. 1) As a result of the coarctation and elevation of systolic pressure, there are changes in the arterial—and particularly the arteriolar system—that take a considerable



**What the  
osteoarthritic  
patient  
perceives as  
“feeling better”..**

Please see last page of advertisement  
for summary of prescribing information.



period of time to reverse. When one looks for evidence of this in the form of arteriolar spasm or increase in the muscle coat of the arterioles in the area of systolic hypertension in these patients, it is not there. 2) Another possible explanation is in an alteration of the baroreceptors, either in the carotid sinus or perhaps in some central mechanism as yet unidentified. There, too, there is no evidence. 3) I think the best explanation for persistence of diastolic hypertension relates to the kind of phenomenon that is seen in correction of renal artery stenosis due to fibromuscular disease. Renal artery stenosis secondary to atherosclerosis should be excluded from this discussion. It occurs in a different age group and is associated with different phenomena, not the least of which is concomitant arteriolar nephrosclerosis as the pathological entity.

In the surgical correction of renal artery stenosis from fibromuscular disease, the course of blood pressure is very similar (postoperatively) to that seen in coarctation. A significant number of these patients have had renal blood flow restored completely, but persist in their hypertension for a period of many months. And a significant number (from 10 to 30%) continue with hypertension even after full correction of the renal artery stenosis. This observation is also true of coarctation.

The fount of all internal medical knowledge related to hypertension is John Laragh, previously of Columbia and now head of the Cardiovascular Center at Cornell. A review of his literature (and, in desperation, a telephone call to him) failed to reveal any new information. He feels that the evidence that would implicate the renin-angiotension system in explanation for the persistence of hypertension in coarctation is really lacking. There are some current and pertinent studies in the literature, mostly in *Circulation* and in *Circulation Research* with dogs, that have had an artificial coarctation introduced at an early age. If one stresses them with a low salt diet for a period of just a few days, hyperreninemia, increased renin production by the kidney, can be demonstrated in response to the sodium loss in about two years. That kind of experimental evidence, however, is not backed up by studies Laragh and others have done in humans. Not all patients who have had coarctation corrected and who persist in their high blood pressure have increased plasma renins.

So, the question Larry Michaelis asked of me stands unanswered. The three potential mechanisms that I discussed briefly with you are not supported by real evidence. This is clearly an

area that is going to take, as they say traditionally, more work.

I would like to close by saying that we have graduated from this school one student who for the rest of his life is going to make comparative palpations of the vessels of the upper and the lower limbs. You have never seen a more excited medical student in all your life than the one who suspected coarctation in today's patient. He changed his vocation from surgery to internal medicine as a result of the experience.

## Conclusion

**Dr. Larry Michaelis:** The ideal age for coarctation repair comes when the patient becomes symptomatic or hypertensive. From a technical viewpoint, the ideal time to repair the disease is in pre-adolescence when the aorta is of adequate size but still easily mobilized, and the child is emotionally able to withstand a major operation. If the disease is discovered in a three or four-year-old though, we do not recommend anti-hypertensive medication in order to allow the child to grow to a larger size. This is usually fraught with more complications than is surgical repair.

In answer to the second question, I suspect that approximately 15% of young people with hypertension have coarctation of the aorta. The third question regards why an aortogram is performed. I think the reason for aortography in today's patient is quite obvious. He did not have the typical chest X-ray findings of coarctation with poststenotic dilatation that one often sees on the plain roentgenogram and for this reason, we suspected that he might have a hypoplastic arch. In fact the arch was small but not so hypoplastic that we had to perform a graft from the ascending to descending aorta. Another reason to perform cardiac catheterization on these patients is the association of other cardiovascular anomalies. Most of the time, especially when the patient is asymptomatic, the associated anomaly is a bicuspid aortic valve. In this situation it is sometimes difficult to tell if the left ventricular hypertrophy and/or the systolic murmur is due to aortic stenosis or to the coarctation. If an aortogram is going to be done anyway, one might just as well determine whether the valve is bicuspid and measure pressures in the left ventricle. If the valve is visualized and a gradient measured, one has a good baseline for future years. Cardiac catheterization is a very safe procedure in most centers and the potential information is worth the minimal risk.

# Army Medicine wants more doctors who specialize.

If you're a physician specializing in pediatrics, anesthesiology, radiology, or internal medicine, we've got a full range of career opportunities for you.

These opportunities are available in a setting that's about as free from non-medical distractions as it's possible for a practice to be. If you're a doctor who's more interested in practicing medicine than the running of a practice, Army Medicine could be perfect for you. Just call your local Army Medical Counselor, and he will discuss specific assignment opportunities with you.

Counselor/Phone Number

Captain Alex Fedorov 312-926-2147 or

Captain John G. Morris 314-268-3846

**Army Medicine. The practice that's practically all medicine.**



**What the  
osteoarthritic  
patient  
perceives as  
“feeling better”..**

Please see last page of advertisement  
for summary of prescribing information.

# Diagnostic Uses for Ultrasonography

ROGER P. SMITH, M.D./URBANA

The noninvasive character of ultrasound has made its diagnostic medical use very attractive. Its intelligent application is dependent on many factors, most importantly, the referring physician's understanding of the information which is obtainable. As with any other adjunctive laboratory technique, its application must be subject to the advantages and limitations of technology, and its interpretation subject to other clinical information. The following is designed to provide a reference as to possible usefulness of ultrasound in various diagnostic situations.

Several general facts should be remembered regarding ultrasound studies. The average working resolution using compound scanning techniques is approximately 1cm x 1/2cm unless special higher frequencies are used. Ultrasonic energy is attenuated, and thus is effectively blocked by gas or bone. Ultrasonography does not require special contrast media, but for all lower abdominal or pelvic examinations a full bladder is essential. (This displaces the gas-containing bowel, elevates the pelvic viscera and provides a reference cyst for comparison.)



ROGER P. SMITH, M.D., is an obstetrician and gynecologist affiliated with the Corle Clinic Association in Urbana. Dr. Smith received his M.D. from Northwestern University Medical

School in 1972. His postgraduate studies included work with the Department of Diagnostic Ultrasound of the University of Oklahoma Medical Center.

Scale of Usefulness	
Interpretation	Code
Experimental only	Ex
Some aid, accuracy <25%	D
Moderate aid, approx. 50%	C
Good, approx. 75% accurate	B
Excellent, approaches 100%	A

## OBSTETRICS

Gestational age—	
single scan 14-34 wks.	A-B
single scan 34+ wks.	C
serial at 20 & 30 wks.	A+
Fetal position	A
Placenta previa	A
Marginal or low placenta	A
Placental size	A
Amniocentesis site selection	A
Multiple gestation	B
Anencephalic	A-B
Hydrocephalic	A-B
Hydramnios	B
Hydatidiform mole	A
Missed abortion	C
Early gestation (6-10 wks.)	A

## GYNECOLOGY AND PELVIS

Normal	B
Cystic masses	A
Pelvic Abscess	B
Ectopic pregnancy	D
Fibroid uterus	B
Solid mass	B
Bladder—size and shape	A
residual	A
tumor	C
diverticuli	C
calculi & foreign body	D
IUD—intrauterine	A
other	D

## FETAL ANATOMY AND PHYSIOLOGY

Fetal cardiography	C
Fetal cardiac activity	A
Fetal respirations	Ex
Fetal kidney function	Ex
Fetal weight	C

## ABDOMEN

Liver abscess	C
Liver tumor	B-C
Liver cysts	A-B
Liver hematoma (capsular)	B
Liver size	A-B
Dilated gall bladder	A
Gall bladder stones	B
Subdiaphragmatic abscess	C
Ascites	A
Pancreatitis	C-D
Pancreas pseudocysts	A
Pancreas cancer	C
Spleen size and shape	A
Spleen hematoma	C

## LUNG

Pleural effusion	B
Lung abscess	C
Mediastinal mass	C
Radiation field planning	A-B

## ECHOCARDIOGRAPHY

Contractility	B
Stroke volume	B
Right vent. hypertrophy	A
Left vent. hypertrophy	A
Atrial septal defect	C
IHSS	B
Congenital heart lesions	D
Mitral stenosis	A
Mitral regurgitation	A
Aortic stenosis	B
Aortic regurgitation	B
Tricuspid stenosis	C
Tricuspid regurgitation	Ex
Pulmonary stenosis	Ex
Aortic root dilatation	A
Aortic root dissection	B
Prosthetic valve—normal	B
dysfunction	B
Ruptured chordae tendinae	C
Atrial myxoma	B
Subacute bacterial endocard.	B
Pericardial effusion	A

## KIDNEYS

Renal cysts—single	A
polycystic	A
Hydronephrosis	B



Dilated calyces	A	Dilated vena cava	B	<b>BREAST</b>	
Renal tumors	C	Dilated portal system	B	Mass identification	Ex
Subcapsular hematoma	C	Peripheral vascular disease	A		
Horseshoe kidney	A	Venous occlusion, thrombosis	A		
Size	A	Plethphymography	A		
Abscess	C			<b>EXTREMITIES</b>	
Perirenal hemorrhage	B			Hematomas	B
Renal vessel abnormalities	Ex			Edema	B
Ureteral abnormalities	Ex	<b>EYES</b>		Cysts	A
Prostatic scan	Ex	Foreign body	B	Tumor	C
		Retinal detachment	B	Wound abscess	B
<b>ECHOENCEPHALOGRAPHY</b>		Retrolubar masses	B		
Midline shift	B	Lens dislocation	B		
Ventricular size	C				
Cephalohematoma	B				
<b>VASCULAR</b>		<b>THYROID</b>		<b>References</b>	
Aneurysms—Aorta	A	Volume	C	A complete list of references for "Diagnostic	
Iliac	B	Cyst vs. solid nodule	B	Uses for Ultrasonography" may be obtained	
Sup. mesenteric	Ex			by writing the author at the Department of	
				Obstetrics and Gynecology, Carle Clinic, 602	
				W. University Ave., Urbana, IL 61801.	

# ...you see as effectiveness

The relief of pain  
and stiffness  
in patients with  
osteoarthritis

The improvement  
in mobility  
in patients with  
osteoarthritis



**Nalfon<sup>®</sup>**  
fenopropfen calcium

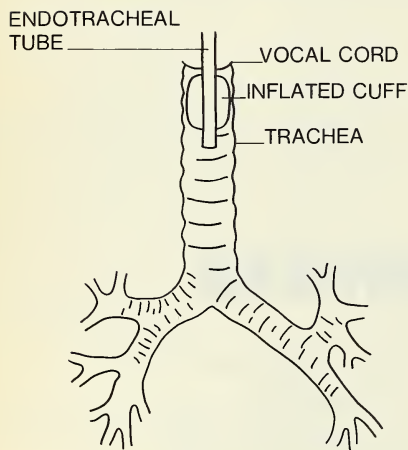
Please see last page of advertisement for summary of prescribing information.



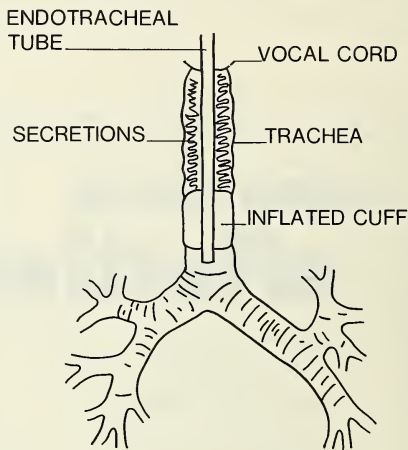
# Correct Positioning of the Endotracheal Tube

By ROBERT H. LIBMAN, M.D./CHICAGO

These diagrams illustrate a simple method of preventing right mainstem endobronchial intubation and the accumulation of secretions (which may be aspirated into the lungs when the cuff is deflated) within the trachea in the intubated patient. Following inflation of the cuff of an endotracheal tube in a newly intubated patient, the tube should be gently withdrawn from the trachea until a slight resistance is felt. This resistance signifies the presence of the cuff adjacent to the vocal cords. The endotracheal tube may then be pushed back into the trachea several millimeters so that there is no physical contact between the cuff and the vocal cords. The tube should be taped in this position.



**CORRECT CUFF POSITION**



**INCORRECT CUFF POSITION**



ROBERT H. LIBMAN, M.D., is director of education in the department of anesthesiology and also director of the Pain Clinic at Illinois Masonic Medical Center. In addition, Dr. Libman is a clinical assistant professor of anesthesiology at the University of Illinois College of Medicine.

## Mental Health Code

(Continued from page 367)

in diagnosis of mental illness.

The section on confidentiality of records and communications is better, but also contains objectionable features. Definitions are slanted, for example, to minimize medical orientation of psychiatric problems. The initial intent (that all records be held confidential) is contradicted by later sections, and particularly by Legal Advocacy Service provisions. Some medical information can be harmful to patients, and specific provisions should be made to mediate access to records through a qualified physician of the patient's choice. There should be provision to control the Human Rights Authority's unlimited access to confidential records. The Commission also has proposed deletion of the therapist's privilege—a current distinctive feature of Illinois law. Finally, treating psychiatrists should be allowed to maintain confidentiality by appointment of separate examining psychiatrists to advise courts on other issues under litigation.

The new legislation would require examining psychiatrists and other physicians to warn prospective involuntary patients that their comments

subsequently may be used against them during commitment hearings. Physicians have repeatedly objected to the introduction of an unnecessary adversarial element into a situation where the patient is already apprehensive and insecure. The presently used Code has been praised for attempting to decriminalize legal proceedings for most mental patients. This "Miranda" provision directly equates mental illness and hospitalization with criminal behavior and imprisonment.

A more concise code would be desirable, preferably one focused on a simple statement of broad principles, leaving administration to existing regulatory powers and review authority of the courts. If enacted, the proposed legislation would result in constant judicial review of everyday clinical decisions. Most acute care is occurring at the community hospital level today, and complex administrative procedures intended primarily for large long-term state facilities will be very troublesome and extremely expensive to manage in smaller units. Because of the pervasive nature of the Commission's recommendations, much more time and study is needed to develop a new mental health code that will truly benefit the people of Illinois. ◀

---

**For your patients with osteoarthritis,  
the recommended initial dosage\* is**

**1 Pulvule® q.i.d.**

\*The dosage may be adjusted in accordance with the patient's condition and changes in disease activity.

The most common type of adverse reaction reported concerned the gastrointestinal system. Dyspepsia occurred most frequently; it was observed in about one of seven patients.



**Nalfon®**  
fenoprofen calcium

Please see last page of advertisement for summary of prescribing information.



## Nalfon® fenoprofen calcium

**Indications and Usage:** Nalfon is indicated for relief of the signs and symptoms of rheumatoid arthritis and osteoarthritis. It is indicated in the treatment of acute flares and exacerbations and in the long-term management of these diseases. The safety and effectiveness of Nalfon have not been established in those rheumatoid arthritis patients who are designated by the American Rheumatism Association as Functional Class IV (largely or wholly incapacitated with patient bedridden or confined to wheelchair, permitting little or no self-care).

**Contraindications:** Nalfon is contraindicated in patients who have shown hypersensitivity to it.

Because the potential exists for cross-sensitivity to aspirin and other non-steroidal, anti-inflammatory drugs, Nalfon should not be given to patients in whom aspirin and other nonsteroidal, anti-inflammatory drugs induce the symptoms of asthma, rhinitis, or urticaria.

**Warnings:** Nalfon should be given under close supervision to patients with a history of upper-gastrointestinal-tract disease and only after the Adverse Reactions section has been consulted. Gastrointestinal bleeding, sometimes severe, has been reported in patients receiving Nalfon.

In patients with active rheumatoid arthritis or osteoarthritis who also have an active peptic ulcer, attempts should be made to treat the arthritis with nonulcerogenic drugs. If Nalfon must be given, the patient should be under close supervision for signs of ulcer perforation or severe gastrointestinal bleeding. In subacute and chronic studies in rats, Nalfon caused interstitial nephritis, glomerulonephritis, and renal papillary necrosis. These abnormalities were dose related and began to appear at doses approximating the human dose. In chronic studies in monkeys, interstitial nephritis also occurred following administration of Nalfon. Although this was seen at doses considerably above the human dose, lower doses were not studied in this species. During the course of the clinical trials, one patient developed bilateral suppurative pyelonephritis, underwent laparotomy, went on to renal failure, and died with a diagnosis of septicemia and renal papillary necrosis. It is not known whether these events were drug related. A few patients developed mild elevations of the BUN during therapy with Nalfon. Since Nalfon is eliminated primarily by the kidney, the drug should not be administered to patients with significantly impaired renal function. It is desirable to perform periodic renal function tests in all patients receiving Nalfon.

**Precautions:** In chronic studies in rats, high doses of Nalfon caused elevation of serum transaminase and hepatocellular hypertrophy. In clinical trials, some patients developed elevation of serum transaminase, LDH, and alkaline phosphatase which persisted for some months and usually, but not always, declined despite continuation of the drug. The significance of this is unknown. It is recommended that periodic liver function tests be performed in patients receiving Nalfon and that the drug be discontinued if abnormalities occur.

The safety of this drug in pregnancy and lactation has not been established, and its use during these events is, therefore, not recommended. Reproduction studies have been performed in rats and rabbits. When fenoprofen was given to rats during pregnancy and continued to the time of labor, parturition was prolonged. Similar results have been found with other nonsteroidal, anti-inflammatory drugs which inhibit prostaglandin synthetase.

In-vitro studies have shown that fenoprofen, because of its affinity for albumin, may displace from their binding sites other drugs which are also albumin bound, and this may lead to drug interaction. Theoretically, fenoprofen, as well as other nonsteroidal, anti-inflammatory agents, could likewise be displaced. Patients receiving hydantoin, sulfonamides, or sulfonyleureas should be observed for signs of toxicity to these drugs. In patients receiving coumarin-type anticoagulants, the addition of Nalfon to therapy could prolong the prothrombin time. Patients receiving both drugs should be under careful observation.

In patients receiving Nalfon® (fenoprofen calcium, Dista) and steroid concomitantly, any reduction of steroid dose should be gradual to avoid the possible complications of sudden steroid withdrawal.

Patients with initial low hemoglobin values who are receiving long-term therapy with Nalfon should have a hemoglobin determination at reasonable intervals.

Peripheral edema has been observed in some patients taking Nalfon; therefore, Nalfon should be used with caution in patients with compromised cardiac function.

Studies to date have not shown changes in the eye attributed to administration of Nalfon. However, because of adverse eye findings in animal studies with some other nonsteroidal, anti-inflammatory drugs, it is recommended that ophthalmologic studies be carried out within a reasonable period of time after chronic therapy with Nalfon has been started and at periodic intervals thereafter.

Since food decreases the blood levels of Nalfon, the drug should be given thirty minutes before or two hours after meals during the daytime.

When phenobarbital, which may enhance the metabolism of Nalfon, is added or withdrawn, dosage adjustment of Nalfon may be required.

Caution should be exercised by patients whose activities require alertness if they experience central-nervous-system side-effects from Nalfon.

Since the safety of Nalfon in patients with impaired hearing has not been established, these patients should have periodic tests of auditory function during chronic therapy with Nalfon.

Nalfon decreases platelet aggregation and may prolong bleeding time. Patients who may be adversely affected by prolongation of the bleeding time should be carefully observed when Nalfon is administered.

**Adverse Reactions: Digestive System**—The most common type of adverse reaction concerned the gastrointestinal system. Dyspepsia occurred most frequently, being observed in about one out of seven patients. Other adverse reactions, in descending order of frequency, were constipation, nausea, vomiting, abdominal pain, anorexia, occult blood in the stool, diarrhea, flatulence, and dry mouth.

Three instances of peptic ulceration and/or gastrointestinal hemorrhage that may have been due to the drug and four instances in which drug relationship was questionable were observed in 3,391 individuals to whom the drug was administered for periods of time ranging up to 165 weeks.

In less than 2 percent of patients, the drug was discontinued because of adverse gastrointestinal reactions.

**Skin and Appendages**—The most common adverse effect was pruritus, which was seen in about one out of ten patients. Other adverse reactions were rash, increased sweating, and urticaria.

In about 1 percent of patients, Nalfon was discontinued because of an adverse effect related to the skin.

**Nervous System**—The most frequent adverse reaction observed was somnolence, which occurred in about one out of seven patients. Other adverse effects, which occurred less frequently, were dizziness, tremor, confusion, and insomnia.

Nalfon was discontinued in less than 0.2 percent of patients because of these side-effects.

**Special Senses**—The most common adverse reaction was tinnitus, which was seen in about one out of ten patients. Other reactions observed, in descending order of frequency, were blurred vision and decreased hearing. In about 0.2 percent of patients, Nalfon was discontinued owing to adverse effects related to the special senses.

**Cardiovascular**—The most frequent adverse effect observed was palpitations. This was noted in about one out of twenty-five patients. Tachycardia was observed less frequently.

In less than 0.5 percent of patients, Nalfon was discontinued as a result of cardiovascular adverse reactions.

**Laboratory**—Anemia was noted in about one out of 500 patients. Therapy with Nalfon had to be discontinued in one patient because of anemia. Increase in alkaline phosphatase, LDH, and SGOT was observed (see Precautions).

**Miscellaneous**—Headache was seen in about one out of seven patients. Less frequently observed, in descending order of frequency, were nervousness, asthenia, dyspnea, peripheral edema, fatigue, malaise, and dysuria. (031677)

Additional information available to the profession on request



**Dista Products Company**  
Division of Eli Lilly and Company  
Indianapolis, Indiana 46206



# The Increasing Abuse of Phencyclidine

By CRAIG V. SHOWALTER, M.D. AND WILLIAM E. THORNTON, M.D./CHICAGO

For the past several years Illinois has seen a progressive increase in the illicit use of phencyclidine, an early analog of the currently useful anesthetic, ketamine. Phencyclidine, 1-(1-phenylcyclohexyl) piperidine, Sernyl®, was developed as an intravenous anesthetic in the late 1950's. During clinical trials it was found to be unpredictable and often resulted in emergence excitement from anesthesia, "hallucinations" and confusion lasting hours to several days. It was rejected as an anesthetic for humans and now is used by veterinarians as an immobilizing agent for sub-human primates (Sernylan).

Phencyclidine first appeared among illicit drug users in San Francisco in 1967 and has gone under a variety of names including the most common designation, PCP. Other names are TAC, peace pill, rocket fuel, crystal and various "dusts" such as angel dust and stardust. The latter names are used when the drug is sprinkled over marijuana and smoked. The illegally produced phencyclidine appears as an off-white powder, sometimes compressed into tablets of various sizes and colors and less frequently in liquid form.

Purity of street samples varies. A July, 1976, report by the Illinois Bureau of Investigation<sup>1</sup> stated that analyzed samples were often 80-90%

phencyclidine. Commonly found adulterants are starch, aspirin, caffeine, a mixture of methyldopa and phenobarbital, and a variety of other psychoactive drugs such as MDA (3,4-methylenedioxy-amphetamine) and LSD (lysergic acid diethylamide). The combination of phencyclidine with MDA is common in the Chicago area. It is significant that 75% of the samples in the Illinois Bureau of Investigation report had been misrepresented as another psychoactive drug. Sellers most often attempt to pass phencyclidine off as "TIC" or "THC", the active ingredient of marijuana, tetrahydrocannabinol, which is essentially non-existent among illicit drug users. Phencyclidine also masquerades as mescaline, peyote, psilocybin ("magic mushroom") and numerous synthetic psychoactive drugs.

Since ingredients for phencyclidine are readily available and synthesis is not complicated, underground chemists have become involved on a large and profitable scale. A seventy-five dollar investment in basic chemicals will yield a pound of phencyclidine worth twenty thousand dollars in street sales. Phencyclidine abuse has thus become a local and national drug problem.

Recently a computerized emergency toxicology program serving metropolitan Detroit reported results of accidental and deliberate poisoning in one thousand patients. Phencyclidine was present in 171 instances making it by far the most frequently found drug.<sup>2</sup> An earlier analysis in the Milwaukee area found 184 of 237 samples of illicit drugs to be phencyclidine.<sup>3</sup> Several cases of accidental ingestion of phencyclidine have been reported in children with serious consequences.<sup>4,5</sup>

## Effects Gradation

When smoked as a "crystal joint" the user attempts to titrate his intake of phencyclidine and the experience is described as a pleasant high. The effects of phencyclidine are markedly dose-related. The low-dose smoker experiences euphoria, paresthesia, and an unsteady gait with uncoordinated behavior resembling ethyl alcohol intoxication. However with increasing doses, par-



WILLIAM E. THORNTON, M.D., is associate professor of psychiatry at the University of Illinois Medical Center, Abraham Lincoln School of Medicine. He is Chief of Consultation-Liaison and the Emergency Psychiatric Services as well as Psychopharmacology Consultant to the Psychiatric In-Patient Service of the University of Illinois Hospital. Dr. Thornton is also a member of the board of directors of the Chicago

Treatment Alternatives to Street Crime (U.S. Law Enforcement Assistance Administration and Illinois Law Enforcement Commission). In addition, he is the president of the board of directors for Substance Abuse Services, Inc., in Chicago.

CRAIG V. SHOWALTER, M.D., is medical director of Substance Abuse Services, Inc., in Chicago. Dr. Showalter is also the former acting medical director for the Illinois Drug Abuse Program (1976), and is engaged in clinical research at the University of Chicago Prairie Avenue Research Clinic.



ticularly by oral or parenteral administration of a misrepresented drug, he may be brought to the primary care or emergency physician with marked anxiety and agitation and appear to be hallucinating and psychotic. This may progress to dysphoria, muscle rigidity, catatonie posturing, myoclonic movements and generalized convulsions. Deaths usually attributed to respiratory depression have been reported.

A striking feature of phencyclidine intoxication is that behavioral effects have lasted for weeks although these effects more typically subside within a few hours.<sup>6-8</sup> Also, a delay of several days before the appearance of severe behavioral toxicity has been reported.<sup>6</sup> It is doubtful if true hallucinations occur with phencyclidine, nor do the users describe the increased introspection or the brilliant visual experiences attributed to the hallucinogens, LSD and mescaline.<sup>9</sup> More often phencyclidine ingestion results in confusion, agitation and psychosis. Body image changes are common and patients describe their limbs as elongated or floating away. Progressive feelings of isolation and depersonalization are frequent and often persist for several hours after other effects have worn off.

### Physical Symptoms

There are numerous physiological findings with phencyclidine intoxication. Muscle weakness and analgesia may be demonstrated. The pupils are most often normal or constricted, although the drug has mild anticholinergic actions.<sup>10</sup> Decreased pupillary light reflexes, nystagmus, absence of corneal and lid reflexes and diplopia may be found. While respiration is usually unaffected, or even stimulated<sup>11</sup> by low doses of phencyclidine, higher doses may result in respiratory depression and arrest.<sup>5</sup> There is a rise in both systolic and diastolic blood pressures attributed to direct action of phencyclidine on alpha adrenergic receptors<sup>12</sup> and to potentiation of the pressor response to the catecholamines.<sup>13</sup> Controlled experiments have shown phencyclidine to be a cardiac depressant.<sup>12</sup> With phencyclidine intoxication the pharyngeal and laryngeal reflexes remain active.<sup>14</sup> This factor, in conjunction with frequent hypertonicity of facial and neck muscles, will make tracheal intubation difficult should it be necessary.

A familiarity with the pharmacology of phencyclidine and its dose related clinical effects is the basis for treatment of phencyclidine intoxication, as there is no specific antidote. The most successful treatment approach has been to place

the patient in a quiet, darkened room. While verbal reassurance ("talking down" drug users on "bad trips") has been effective in many situations (such as LSD intoxication) it has not been as successful in phencyclidine intoxication, since it may have the effect of intensifying the patient's agitation. In low or moderate dose intoxications, observation in a non-threatening environment for a few hours may be all that is necessary for behavioral management. Parenteral use of diazepam is often useful in management of agitation, myoclonus and seizures. It is questionable if there is need for antipsychotic agents such as chlorpromazine (Thorazine) except possibly for management of prolonged behavioral effects or aggravation of preexisting thought disorders. These prolonged effects will likely require hospitalization in a psychiatric unit. Generally, phenothiazines and other drugs with anticholinergic effects are best avoided in any unidentified drug ingestion. Many illicit drugs are adulterated with anticholinergic drugs, especially the belladonna alkaloids, and phencyclidine has anticholinergic actions of its own. Therapeutic doses of phenothiazines have resulted in significant hypotension in treatment of phencyclidine intoxication.<sup>15</sup> If an antipsychotic drug is deemed necessary the use of a butyrophenone such as haloperidol (Haldol) is preferred.

### Emergency Treatment

While most cases of phencyclidine intoxication can be managed with sensory isolation and diazepam, the possible medical complications of high dose ingestion should be anticipated. Ventilatory support may be necessary. Hypertension is a frequent finding and management of this complication should be included in the treatment plan. In a case of severe hypertension following phencyclidine ingestion, diazoxide (Hyperstat) was effective in lowering blood pressure.<sup>4</sup> In view of the autonomic action of phencyclidine an alpha adrenergic blocking agent may be useful in lowering blood pressure. Phencyclidine is metabolized by the liver<sup>16</sup> and a considerable amount is also excreted unchanged by the kidney.<sup>5</sup> Hydration should be adequate to promote renal excretion but renal function must be monitored, as high doses of phencyclidine are reported to impede urinary output.<sup>14</sup> In suspected cases of high dose oral ingestion, gastric lavage would be indicated. A urine specimen sent to the toxicology laboratory will be helpful should the patient develop the prolonged behavioral effects of intoxication. Possible delay in receiving a report, even from those laboratories prepared to test for

phencyclidine, requires that a working diagnosis be made and treatment begun. Evaluation of suspected phencyclidine poisoning should rule out other organic etiologies, a primary psychosis, and the adverse effects of another drug. Prevalence of phencyclidine usage in Illinois warrants its consideration in any suspected case of drug intoxication or acute delirium state.

### Summary

Many cases of phencyclidine ingestion can be successfully managed with sensory isolation and the judicious use of diazepam; others will require physical restraint, sedation, and continued behavioral observation. Serious medical complications such as seizures, coma, hypertension, respiratory failure and death are frequently reported and must be anticipated in any treatment plan for suspected phencyclidine toxicity. The use of therapeutic drugs which may in themselves be additive to the effects of phencyclidine would be determined by the individual case. ◀

### References

A complete list of references for "The Increasing Abuse of Phencyclidine" may be obtained by writing the Illinois Medical Journal, 55 E. Monroe, Suite 3510, Chicago, 60603.

## COOK COUNTY Graduate School of Medicine CONTINUING EDUCATION COURSES STARTING DATES - 1977

STATE & NAT'L. BD. REVIEW, CLINICAL, May 2  
SPECIALTY REVIEW MEDICINE, CERTIFYING, May 1 and May 12  
SPECIALTY REVIEW DERMATOLOGY, One Week, May 2  
ADVANCES IN SURGERY, One Week, May 9  
SPECIALTY REVIEW PEDIATRIC CARDIOLOGY,  
Two & half days, May 12  
REFRESHER COURSE IN RADIATION SCIENCE, May 16  
SPECIALTY REVIEW OBSTETRICS & GYNECOLOGY, May 16  
SPECIALTY REVIEW ANESTHESIOLOGY, May 29  
RADIATION ONCOLOGY, Four and a half days, June 1  
ADVANCED CARDIOLOGY, One Week, June 6  
MANAGEMENT OF COMPLICATIONS IN SURGERY, June 6  
ADVANCED PERIPHERAL VASCULAR SURGERY, July 18  
SPECIALTY REVIEW FAMILY PRACTICE, August 15  
SPECIALTY REVIEW ORTHOPAEDICS, August 31  
QUALITY ASSURANCE EVALUATION, Three days, September 8  
SPECIALTY REVIEW ENDOCRINOLOGY, September 12  
SPECIALTY REVIEW MEDICAL ONCOLOGY, September 12

*Information concerning numerous other continuation courses available upon request.*

**Address:**  
**REGISTRAR, 707 South Wood Street,**  
**Chicago, Ill. 60612**

## EKG

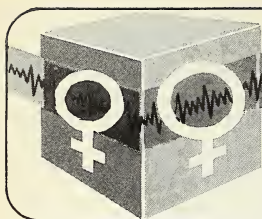
(Continued from page 321)

**Answers: 1. E 2. E**

The rhythm strip shows a junctional rhythm with aberrant intraventricular conduction and a normal QRS duration. The first four beats of the top strip are junctional at a rate of 68/min. Then the sinus captures the ventricle and the QRS morphology changes. The last three beats in the top strip are fusion beats with slightly different contributions from the junctional and the sinus pacemakers. The A-V dissociation is best seen in the middle strip where the sinus P waves march through the junctional QRS. Those beats which are clearly sinus in origin (beats 5-10 in the top strip) have ST segment depression and T wave inversion which are compatible with

ischemic heart disease. The incidence of A-V junctional arrhythmias in ischemic heart disease varies from approximately 2 to 20% because the literature does not define rates of the junctional pacemaker and whether it is paroxysmal or non-paroxysmal with sufficient precision. In our case, the junctional pacemaker was almost at the same rate as the sinus pacemaker. There are also great differences reported in mortality if this arrhythmia is seen with acute myocardial infarction. However, the mortality in the setting of acute myocardial infarction may be due to the extent of myocardial damage rather than the arrhythmia itself. Our patient remained asymptomatic and no treatment was given. The arrhythmia was seen only once during his hospitalization which was otherwise uneventful.

For more information on arrhythmias in ischemic heart disease see the extensive review by Dr. J. T. Beggan, Jr. and colleagues (*Progress in Cardiovascular Diseases* 19:255, January 1977).



## *pulse...* of the doctor's wife

MRS. EUGENE VICKERY, Editor

### KEY LINES:

## "Who, What, Why"

BY MRS. EDWARD SZEWCZYK, PRESIDENT ISMSA

"Just what do you do in Medical Auxiliary, anyway—write receipts or what?" That's the type of question that quickly clears your head and brings it directly down to earth when you're a newly-nominated president-elect of the medical auxiliary for the whole state of Illinois. Sounds very impressive, but it doesn't help you to come up with a good, intelligent, knowledgeable, public-relations type answer.

Nevertheless, it is *this* question that has come up most often in recent months. My personal reaction to Medical Auxiliary has been a reflex for so many years that I fear it has become a feeling rather than a thinking operation. I became so wrapped up with the beauty of medicine and some of its particular problems in this day and age that it never occurred to me that everyone didn't understand. Most alarming is the fact that many auxiliary members are completely unaware of the good works and serious projects put forth by local, state and national auxiliary.

First, let us go back fifty years ago when a group of doctors' wives in Illinois decided there was a need for a medical auxiliary in our state. (Nationally, some groups were in progress a few years before 1928.) These visionary ladies called the new organization the Woman's Auxiliary to the Illinois State Medical Society—"auxiliary"—meaning an assisting or supplementary group or organization. This has been our role in Illinois for the past fifty years. The name has since been changed to Illinois State Medical Society Auxiliary.

### Statement of Purposes

The purposes were (and are) to assist the Illi-

nois State Medical Society in its programs to improve the quality of life through health education and services; to advise and coordinate the activities of component auxiliaries; and to cultivate friendly relationships and promote mutual understanding among physicians' families.

Medical Auxiliary members have not "sat back" and rested on the laurels of the so-called "good doctor." One look at the national auxiliary's communications tool called "Project Bank" will tell you that over 300 programs are listed—a ready reference file of valuable community action originated by auxiliary members all over the nation. Among these programs you will find nutrition, drugs abuse, child abuse, immunization, blood donor, safety, parenting, screening, VD awareness, and many other community service needs. During the past year, the Medical Society has taken up the banner, together with the PTA, against TV violence—and the Medical Society's supplementary group is ready to stand behind the doctors, and facilitate a goal necessary for the mental health of all our citizens, especially our young.

The Illinois State Medical Auxiliary is particularly concerned this year with the young. "Teach the Children" will be the motto for our golden anniversary year as we appreciate the past, but anticipate the future. Our various chairmen will be working and planning programs oriented toward child health education. They will present these ideas and suggestions to counties this summer—in time to put them in action within the coming auxiliary year. Many individuals and organizations are deeply interested in health education and services, but medical peo-



ple should be "up in front" leading the way.

**Our second purpose is to advise and coordinate the activities of component auxiliaries.** County auxiliaries *ARE* the ISMA, of course. But alone, one county may drift or even worse, go astray. Together, we can do more. We can keep one another informed. We can infuse enthusiasm from many other members and their projects. We can help each other by keeping posted about medical legislation. Through the Legislative Effort Group System, over 5000 volunteers are currently active in promoting activities to support health related legislation. As I said—we *can do more together.*

We also work together to raise money for medical education and research. Last year the auxiliary helped to raise a total of \$24,721,021 for unrestricted grants to medical schools, loans for medical students, interns and residents and substantial funds for research grants, scholarships and programs to improve the quality and availability of medical care in underserved areas. Illinois received the top award in the nation for the amount it contributed to this fund. We put it all together last year and we saved the pattern for this coming year.

The state auxiliary encourages each county to develop programs suiting their particular community problems. It also communicates ideas from each level—county, state and national—to implement programs, fill in gaps and improve basic programs. It keeps counties informed of national ideas and goals and generally acts as the "mother hen" to the thirty-four counties organized in Illinois. The members-at-large are very crucial to the Illinois State Auxiliary family. We have been striving diligently in the past year to find an effective way of communicating with these important members. This search will continue with great force during this coming year. The Junior Affiliate Memberships will also become one of our prime membership concerns.

**Our third purpose—to cultivate friendly relationships and promote mutual understanding among physicians' families.** Have we somewhere along the way discarded this idea—or perhaps we are too blase today for such a loving idea? Medical families do share common problems and, of course, happiness. We don't, by any means, suggest a secret, exclusive club closed to anyone but doctors' families, but we do present the idea of kindness, caring, assistance, interest and a general concern for those involved in the important job of caring for the health of their fellow men. *Be supportive and you will be constructive.*

One of the least known, but very significant projects of the ISMA is the Benevolence Fund. It encourages contributions to take care of our own medical people when they encounter hard times. The ISMS, with representation from the Auxiliary, sets the requirements and disposition of funds. This is all handled within the confines of total confidentiality and imposes no embarrassment to the persons receiving the funds. Working together and for each other makes such a fine service possible.

Serious things are being done by ISMA, but "a spoonful of sugar makes the medicine go down." We do encourage a bit of fun in the form of lunches, international dinners and endless numbers of "social" times. We even have more fun together.

The next time I'm asked the startling question about "what does Medical Auxiliary do," I shall be prepared. Perhaps I'll even tell them we are so organized, we have a Treasurer to write the receipts!

Unlock potential!

---

## Viewbox

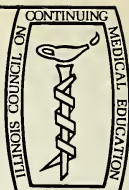
(Continued from page 328)

**DIAGNOSIS: Agenesis of the left lung**—The radiographic findings in this case are a total absence of aerated lung in the left hemithorax with overexpansion of the right lung herniating across the mediastinum. The marked loss in volume is indicated by the closeness of the left ribs and elevation of the left hemidiaphragm. About 60% of patients with agenesis of the lung are said to have other congenital anomalies. Close inspection of the dorsal spine on the PA film reveals multiple hemivertebra in the region of D 3, 4 and 5 which should alert the examiner to the possibility that this is undoubtedly on the basis of a congenital lesion. Other associated anomalies are patent ductus arteriosus, tetralogy of Fallot (this patient was cyanotic and did have this anomaly on investigation). Angiography revealed a complete absence of the left pulmonary artery.



# ISMS Guide to Continuing Medical Education

Compiled for Illinois physicians by the  
ILLINOIS COUNCIL ON CONTINUING MEDICAL EDUCATION  
55 E. Monroe St., Suite 3510 • Chicago, IL 60603 • (312) 236-6110



Items for this Calendar must be received 90 days prior to the event. Those received earlier may appear in up to three monthly issues.

**WARNING!** Items for this Calendar come from many sources, often far in advance of the publication date. Sometimes, cancellations or changes in date, place or time occur too late to be corrected before publication. You are urged to contact the sponsoring organization to confirm information given below.

## JUNE

### ADVANCED CARDIOLOGY

**For:** Cardiologists. Lecture, June 6 (one week), 8:30 am, Cook County Graduate School of Medicine, Chicago. **Speaker:** Kenneth Rosen, M.D. (Coordinator). **Fee:** \$200. **CME Credit:** 30 hrs. **AMA Cat. 1, Reg. Limit:** 35. **Sponsor, contact:** Cook County Graduate School of Medicine, 707 S. Wood St., Chicago, IL 60612. **Attn:** Robert Baker, M.D., Dean. Telephone: (312) 733-2800.

### Cardiology

### NORTHERN MICHIGAN SUMMER CONFERENCE

**For:** Family Physicians, Internists, Pediatricians. 5-day workshop, June 20-24, Shanty Creek Lodge, Bellaire, Michigan. **CME Credit:** AAP Elective; **AMA Cat. 1, AOA, Fee:** To be determined. **Sponsor, contact:** Office of Continuing Education, Dept. of PGM/HPE, Towles Center, Univ. of Mich. Medical Center, Ann Arbor, MI 48109. **Attn:** Betta Armbruster. Telephone: (313) 763-0081.

### Family Medicine

### Family Medicine, Gerontology

**HEALTH CARE AND HUMAN NEED IN SEX AND AGING**  
**For:** Physicians, Nurses, Therapists. 2-day workshop, June 3, 9:00 AM-8:45 PM and June 4, 9:00 AM-5 PM, Chicago. **Speaker:** Dr. Margaret Hucyk. **CME Credit:** 16 hrs. **AMA Cat. 1, Fee:** \$75. **Reg. Limit:** 100. **Reg. Deadline:** May 1. **Sponsor, contact:** National Institute for Human Relations, 180 N. Michigan Ave., Chicago, IL 60601. **Attn:** Jessie Potter. Telephone: (312) 236-0051. **Co-sponsor:** University of Illinois School of Public Health.

### Family Therapy

### PERSONAL/PROFESSIONAL GROWTH WORKSHOP FOR THERAPISTS: WITH/WITHOUT PARTNERS

**For:** Physicians and Mental Health Practitioners. Three-day workshop, June 23, 7:30 PM-10:30 PM; June 24, 9:00 AM-9:00 PM; June 25, 9:00 AM-1:00 PM, Oak Park, IL. **Speaker:** Chuck Kramer and Jan Kramer. **CME Credit:** 20 hrs. **AMA Cat. 1, Fee:** \$200 (couple); \$125 (individual). **Reg. Limit:** 16. **Sponsor, contact:** The Family Institute of Chicago/Center for Family Studies, Ten East Huron, Chicago, IL 60611. **Attn:** Belinda Stone. Telephone: (312) 440-1414. **Co-sponsor:** Institute of Psychiatry, Northwestern Memorial Hospital and Northwestern University Medical School.

### Hematology

### BLOOD BANKING FOR MEDICAL TECHNOLOGISTS

**For:** Medical Technologists. 2-day workshop, June 2-3, Towles Center, MI. **CME Credit:** AAP Elective; **AMA Cat. 1, CEU credits, Fee:** To be determined. **Sponsor, contact:** Office of Continuing Education, Dept. of PGM/HPE, Towles Center, Univ. of Michigan Medical Center, Ann Arbor, MI 48109. **Attn:** Betta Armbruster. Telephone: (313) 763-0081. **Co-sponsor:** MABB-MSMT.

### PEDIATRIC POSTGRADUATE COURSE

**For:** Pediatricians, Family Practitioners, Ped. & F.P. Residents. One day symposium, June 8, 9:00 AM-3:00 PM, Chicago. **Speakers:** Philip Dodge, M.D., Michael Cohen, M.D., Victor Chernick, M.D. **CME Credit:** To be determined. **Fee:** None. **Sponsor:** The Children's Memorial Hospital, Dept. of Peds., Northwestern Univ.-McGraw Medical Center. **Contact:** Wayne Borges, Medical Director for Education, The Children's Memorial Hosp., 2300 Children's Plaza, Chicago, IL 60614. Telephone: (312) 649-4302.

### Pediatrics

### Pediatrics

### HEPATITIS IN THE OLDER CHILD

**For:** All physicians. Lecture series, June 1, 1977, Chicago, 9:00 AM. **Speaker:** John D. Lloyd-Still, M.D. **CME Credit:** 1 hr. **AMA Category 1, Fee:** None. **Sponsor:** St. Joseph Hospital, Office of Medical Education, 2900 Lake Shore Dr., Chgo. **Contact:** Tina Dabrowski. Telephone: 975-3454.

### CHRONIC INFLAMMATORY BOWEL DISEASE

**For:** All physicians. Lecture Series, June 8, 1977, Chicago, 9:00 AM. **Speaker:** John D. Lloyd-Still, M.D. **CME Credit:** 1 hr., **AMA Category 1, Fee:** None. **Sponsor:** St. Joseph Hospital, Office of Medical Education, 2900 Lake Shore Dr., Chgo. **Contact:** Tina Dabrowski. Telephone: 975-3454.

### CONSTIPATION

**For:** All physicians. Lecture Series, June 15, 1977, Chicago, 9:00 AM. **Speaker:** John D. Lloyd-Still, M.D. **CME Credit:** 1 hr., **AMA Category 1, Fee:** None. **Sponsor:** St. Joseph Hospital, Office of Medical Education, 2900 Lake Shore Dr., Chgo. **Contact:** Tina Dabrowski. Telephone: 975-3454.

### Pediatrics

### Pulmonary Disease

### PULMONARY DISEASE WORKSHOP

**For:** Family Physicians, Internists. 3-day workshop, June 8-10, Towles Center, MI. **CME Credit:** AAP Prescribed; **AMA Cat. 1, Fee:** To be determined. **Sponsor, contact:** Office of Continuing Education, Dept. of PGM/HPE, Towles Center, Univ. of Mich. Medical Center, Ann Arbor, MI 48109. **Attn:** Betta Armbruster. Telephone: (313) 763-0081. **Co-sponsor:** Michigan Academy of Family Physicians.

### Radiology

### RADIATION ONCOLOGY

**For:** Radiologists. Lecture, June 1 (3 1/2 days), 8:00am, Cook County Graduate School of Medicine, Chicago. **Speaker:** John D. Hibbs, M.D. (Coordinator). **CME Credit:** 34 hrs. **AMA Cat. 1, Fee:** \$200. **Reg. Limit:** 75. **Sponsor, contact:** Cook County Graduate School of Medicine, 707 S. Wood St., Chicago, IL 60612. **Attn:** Robert J. Baker, M.D., Dean. Telephone: (312) 733-2800.

### Surgery

### THE MANAGEMENT OF COMMON SURGICAL PROBLEMS

**For:** Surgeons. Postgraduate course, June 16-17, 1977, Alumni Center for Continuing Education, Northwestern Univ. Medical School, Chgo. **CME Credit:** 12 hrs., **AMA Category 1, Fee:** \$125.00. **Reg. Deadline:** June 12, 1977. **Sponsor:** Northwestern University Medical School, 303 E. Chicago Ave., Chgo. **Contact:** Judith Burnison. Telephone: (312) 649-8533.

### Surgery

### MANAGEMENT OF COMPLICATIONS IN SURGERY

**For:** Surgeons. Lecture, June 6 (4 days), 8:00am, Cook County Graduate School of Medicine, Chicago. **Speaker:** Robert J. Baker, M.D. (Coordinator). **CME Credit:** 28 hrs. **AMA Cat. 1, Fee:** \$175. **Reg. Limit:** 55. **Sponsor, contact:** Cook County Graduate School of Medicine, 707 S. Wood St., Chicago, IL 60612. **Attn:** Robert J. Baker, M.D., Dean. Telephone: (312) 733-2800.

### Surgery

### SURGICAL MANAGEMENT OF PENETRATING NECK TRAUMA

**For:** Physicians, Surgeons. **CME Lecture, June 11, 8:00 AM, Evanston, Speaker:** John D. Salletta, M.D., Cook County Hospital. **CME Credit:** 1 hr. **AMA Cat. 1, Fee:** None. **Sponsor, contact:** St. Francis Hospital, 355 Ridge Ave., Evanston, IL. **Attn:** M. P. Byrne, M.D., Director of Medical Education. Telephone: (312) 492-6227.

### Urology

### FIRST ANNUAL UROLOGY CONFERENCE

**For:** Urologist. Postgraduate Course, June 10-12, 1977, Chicago. **CME Credit:** 16 hrs., **AMA Category 1, Fee:** \$125.00. **Reg. Deadline:** June 6, 1977. **Sponsor:** Northwestern University Medical School, 303 E. Chicago Ave., Chgo. **Contact:** Judith Burnison. Telephone: (312) 649-8533.

## JULY

### Family Therapy

### INTRODUCING FAMILY SYSTEMS (Introductory)

**For:** Physicians and Mental Health Practitioners. One-week course, July 11-15, 9:00 AM-3:30 PM Daily, Chicago. **Speaker:** Nancy Reed, ACSW. **CME Credit:** 35 hrs. **AMA Cat. 1, Fee:** \$130. **Reg. Limit:** 24. **Sponsor, contact:** The Family Institute of Chicago/Center for Family Studies, Ten East Huron, Chicago, IL 60611. **Attn:** Belinda Stone. Telephone: (312) 440-1414. **Co-sponsors:** Institute of Psychiatry, Northwestern Memorial Hospital and Northwestern University Medical School.

### Family Therapy

### ON BECOMING A FAMILY THERAPIST (Intermediate)

**For:** Physicians and Mental Health Practitioners. One-week course, July 18-22, 9:00 AM-3:30 PM Daily, Chicago. **Speaker:** Robert E. Rutledge, ACSW. **CME Credit:** 35 hrs. **AMA Cat. 1, Fee:** \$130. **Reg. Limit:** 24. **Sponsor, contact:** The Family Institute of Chicago/Center for Family Studies, Ten East Huron, Chicago, IL 60611. **Attn:** Belinda Stone. Telephone: (312) 440-1414. **Co-sponsors:** Institute of Psychiatry, Northwestern Memorial Hospital and Northwestern University Medical School.

### Family Therapy

### THE PRACTICING FAMILY THERAPIST (Advanced)

**For:** Physicians and Mental Health Practitioners. One-week course, July 25-29, 9:00 AM-3:30 PM Daily, Chicago. **Speaker:** Lynn Parker Wahl, ACSW. **CME Credit:** 35 hrs. **AMA Cat. 1, Fee:** \$130. **Reg. Limit:** 20. **Sponsor, contact:** The Family Institute of Chicago/Center for Family Studies, Ten East Huron, Chicago, IL 60611. **Attn:** Belinda Stone. Telephone: (312) 440-1414. **Co-sponsors:** Institute of Psychiatry, Northwestern Memorial Hospital and Northwestern University Medical School.

### Surgery

### ADVANCED PERIPHERAL VASCULAR SURGERY

**For:** Surgeons. Lecture, July 18, 1977, Chicago. **Speaker:** Robert J. Baker, M.D. **CME Credit:** 40 hrs., **AAP Elective, 40 hrs., AMA Category 1, Fee:** \$225.00. **Reg. Limit:** 60. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood St., Chgo. **Contact:** Robert J. Baker, M.D. Telephone: (312) 733-2800.

## Cytology

**"WORKSHOPS IN DIAGNOSTIC CYTOLOGY—1977"**  
For: Pathologist & Cytotechnologists. 5 day workshop. August 8-12, 8:00 AM-5:00 PM daily. 328 S. Wolcott, Chicago. Speaker: Dr. Elizabeth McGraw. CME Credit: 36 hrs. Fee: \$200.00. Reg. Deadline: July 26, 1977. Reg. Limit: 60. Sponsor: University of Illinois College of Medicine, Veterans Administration West Side Hosp., 1853 W. Polk St., Chgo. Contact: JoAnn Kohn. Telephone: (312) 996-8025.

## Family Medicine

**SPECIALTY REVIEW FOR FAMILY PRACTICE**  
Lecture, August 15, 1977, 10½ days, Cook County Graduate School of Medicine, 707 S. Wood St., Chicago. Speaker: Harry Marchmont-Robinson, M.D. CME Credit: AAPF elective, AMA Category 1. Fee: \$350.00. Reg. Limit: 150. Sponsor: Cook County Graduate School of Medicine. Contact: Robert J. Baker, M.D. Telephone: (312) 733-2800.

## Orthopaedics

**SPECIALTY REVIEW IN ORTHOPAEDICS**  
Lecture, August 31, 1977, One week, Cook County Graduate School of Medicine, 707 S. Wood St., Chicago. Speaker: Peter C. Altner, M.D. CME Credit: AAPF elective, AMA Category 1. Fee: \$250.00. Reg. Limit: 360. Sponsor: Cook County Graduate School of Medicine. Contact: Robert J. Baker, M.D. Telephone: (312) 733-2800.

## ATTENTION: CME PLANNERS

ICCME can help you build a high-quality CME program, worthy of accreditation, to help your colleagues satisfy the new Illinois Mandatory CME Law.

ICCME offers:  
**How to Start a CME Program** and other publications

Informal consultation by our staff  
The "Workshop on CME Leadership" for leaders of hospital medical staffs and medical societies  
The Illinois Hospital CME Consultation Service

Take advantage of your State Society's unique Council. For information, write or call:

Illinois Council/CME  
55 E. Monroe, Suite 3510  
Chicago, IL 60603  
(312) 236-6110

## Recent CME Accreditations

The ISMS Committee on Accreditation has recently approved the CME program of these institutions:

- Central Community Hospital Chicago
- Illinois Central Community Hospital Chicago
- Ravenswood Hospital Medical Center Chicago
- St. Elizabeth Hospital Danville
- St. Mary's Hospital Streator
- Louis A. Weiss Memorial Hospital Chicago

## CME Planning Aids

ICCME continually develops a variety of "how-to" material for CME Planners—DME's, program chairmen of hospitals and medical societies (both specialty and geographic), and others. All items are FREE to Illinois physicians and CME sponsors.

To learn what's currently available, request the "CME Planning Aids Order Form"; write or call . . .

Illinois Council/CME  
55 E. Monroe St., Suite 3510  
Chicago, IL 60603  
(312) 236-6110

## Cancer—Educational Materials

A variety of reprints, motion pictures (8mm and 16mm), tapes, slides, and exhibits are available from the American Cancer Society's Illinois office. That agency also maintains a speakers bureau. Topics covered include both physiological and psychological aspects; material is available to meet the needs of physicians, nurses, and patients.

For full information, write to . . .  
Illinois Division, Inc.  
American Cancer Society  
37 South Wabash Avenue  
Chicago, IL 60603

## Would an Outside View Help your Hospital CME?

The Illinois Hospital CME Consultation service can improve your in-hospital CME by helping you to build an up-to-date conception designed to enhance individual physicians' full clinical potential—and discard stereotyped group efforts to "keep up." The two-part process begins with self-analysis using a unique 16-page booklet—FREE to Illinois hospitals. The second part involves a personal visit and report by an expert on effective in-hospital CME; for the Consultant's visit, a modest charge is necessary to cover his honorarium, travel, and related costs.

For full information, ask for the "Consultation booklet"; write or call . . .

Illinois Council/CME  
55 E. Monroe St., Suite 3510  
Chicago, IL 60603  
(312) 236-6110

## Have You Seen the New Illinois Mandatory CME Law?

In November, 1975, the Illinois Legislature passed a law requiring continuing medical education for re-licensure. The law will be administered by the State Department of Registration and Education. FREE copies of the law are available; write or call . . .

Illinois Council/CME  
55 East Monroe St., Suite 3510  
Chicago, IL 60603  
(312) 236-6110

## Your Personal Learning Plan

Are you satisfied that your CME is producing full benefits for the time (and money) invested? If you've any doubts, try *Your Personal Learning Plan*, a 32-page pamphlet intended to help the individual physician plan CME in a systematic fashion.

While written chiefly for primary-care practitioners—family physicians, internists, pediatricians—the pamphlet can also be useful to those specialists who ordinarily deal with a smaller range of medical problems.

A unique feature of this handbook is a special set of worksheets—similar in format to the patient medical record—to help you think through and record YOUR personal learning plan.

Any Illinois physician (MD or DO) may have a copy FREE upon request; simply write "Personal Learning Plan" on your prescription form, and mail to ICCME (address above). To all others, the cost is \$1.00/copy postpaid (90c each in quantities of 100 or more).

## CANCER INFORMATION SERVICE FOR ILLINOIS

800-972-0586

Illinois physicians may call this toll-free number for quick, easy access to a panel of cancer specialists for specific patient consultation.

Sponsored by:  
Illinois Cancer Council  
37 South Wabash Avenue  
Chicago, IL 60603



Travel Medical Seminar for all Members and Families of

# ILLINOIS STATE MEDICAL SOCIETY

## Black Sea/Greek Isles

## Air/Sea Cruise

Come join us on a deluxe cruise that includes Athens and the Greek isles, throbbing Istanbul, beach resorts along the Russian Riviera, and Romania with an optional excursion to Bucharest, the "Paris of the Balkans."

**We depart Chicago On September 23 And return on October 6**

Never will your travel dollars have been spent so wisely.

Cost for the entire vacation, which includes round-trip airfare via chartered jet; comfortable staterooms aboard prestigious Sun Line's Stella Oceanis; gourmet dining; transfers and baggage handling; a competent Travel Director; transportation and port taxes; pre-arranged optional shore excursions; gala parties and nightly entertainment, is as low as \$1398

Make plans today to join us for a memorable, carefree holiday at charter cost savings.

Send to: Illinois State Medical Society  
55 East Monroe  
Chicago, Illinois 60603

Enclosed is my check for \$\_\_\_\_\_ (\$100 per person) as deposit.

Name(s) \_\_\_\_\_

(LAST)

(FIRST)

(SPOUSE)

Home Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

A Non-Regimented **INTRAV** Deluxe Adventure

**Blue Cross®  
Blue Shield®**



# REPORT

## FOR *Illinois Physicians*

### Supplemental Coverage Helps Meet Medicare Expenses

Designed to help cover health care expenses not paid in full by the Medicare program, Blue Cross and Blue Shield offers a program to supplement Medicare allowances.

Persons eligible for Medicare as individuals or through a group may enroll in the Blue Cross 65 and Blue Shield 65 program. At age 65, Blue Cross and Blue Shield members are transferred to the Medicare supplemental program.

Two types of coverage are offered:

(1) Blue Cross 65/Blue Shield 65 (Code 6E):

This is the standard supplemental to Medicare for group and direct-pay members. For Medicare Part B services, Blue Shield will pay 20% of doctors' Usual and Customary charges for:

- In-hospital professional services of physicians
- Physicians' visits to patients in Extended Care Facilities
- Radiation therapy, including X-ray therapy or radioisotope therapy for cancer, wherever performed.
- Out-patient or office surgery, care of fractures and complete dislocations including the initial X-rays and accident care within 72 hours.
- Surgical assistance.

If the member has not paid the physician's fee, the payment of 20% Usual and Customary charges for services covered under the Blue Shield 65 program will be made directly to the doctor after the Physician's Service Report is processed.

Because our Blue Shield Claims Department operates independently of the two Medicare Part B carriers in Illinois, a separate claim for supplemental benefits must be filed directly with Blue Shield. A Physician's Service Report should be completed the same way as for those members under 65, and should include a full description of service performed and the doctor's usual charge for each service. Services to patients may be reported at the same time, or afterwards.

(2) Series 65 Group (group membership only):

These programs are written to assure that the "over 65" member of a group, whether working or retired, will receive as much coverage between Medicare benefits and Blue Shield supplemental coverage as employees under 65 would receive from their basic certificates.

Under this plan, the amount payable by Medicare Part B for a covered service is deducted from what normally would have been paid under the group's basic certificate. The balance is the benefit paid by Blue Shield. In no instance will the program duplicate Medicare payments.

Because of the nature of the Series 65 Group program (i.e., relationship to the group's basic contract) claims cannot be processed without a copy of the Explanation of Medicare Benefits. This form is sent to the member after Medicare has adjudicated its claim. It is the responsibility of the member to supply a copy of this form to Blue Shield directly or through the physician's office.

Only with the Explanation of Medicare Benefits plus a completed Physician's Service Report can the eligible benefits of these programs be determined. When the basic coverage in the group is written at 100% of Usual and Customary charges, the supplemental coverage fills the Medicare gaps fully. Where basic group coverage allowances are less than the Medicare payment, no supplemental benefits are payable. There are a number of variations between these extremes and the application of Medicare's \$60 deductible becomes an important factor in determining whatever benefits are payable.

A Blue Shield Physician's Service Report form should always be completed and submitted to obtain benefits supplemental to Medicare Part B, regardless of the member's contract. A Service Report and completed SSA-1490 Request for Medicare Payment form may be submitted together, but please do not staple them together as they are routed to separate claims departments. Pre-printed Blue Shield claims envelopes are available for your convenience upon request.



## Reasonable Charges Involving Exclusion of Refractive Services

Refractive procedures of the eye are excluded from coverage and consequently not reimbursable by the Medicare program. Although a refraction is a separate and distinct procedure, physicians have seldom routinely identified and separately charged patients for this procedure. Generally, the practice has been for the physician to make a single inclusive charge, either for an initial diagnostic examination or a follow-up visit for further diagnosis and treatment. This charge covered the physician's charges for all the procedures performed, including any procedures that may have been performed to determine the refractive state of the eyes.

In November, 1975, instructions were received from the Bureau of Health Insurance which stated that whether the physician makes a single inclusive charge, or a separate charge for refractive services, the charge for the refractive services should be excluded before a reasonable charge determination for an eye examination can be made.

If the bill for the eye examination shows a separate charge for the refraction, and other separate charges for the covered eye services, the carrier can easily determine the reasonable charge. When a single inclusive charge is made for an eye examination, certain guidelines must be followed to determine the charge for the refractive services.

In a comprehensive ophthalmological examination or an initial eye examination, which may include refractive procedures, the value of the procedures performed to determine the refractive state of the eyes may generally be expected to be about 20% of the charge submitted by the physician. For example, if the submitted charge for an initial eye examination is \$30.00, the following calculations would be made:

$\$30.00 \text{ multiplied by } 20\% = \$6.00$

The charge for the refraction is then \$6.00.

$\$30.00 \text{ minus } \$6.00 = \$24.00$

The submitted charge for the initial eye examination is then \$24.00.

The Explanation of Medicare Benefits would show the "amount billed" or the "total charges" on two separate lines; the "amount billed" or the "total charges" for the initial eye examination as \$24.00 and the "amount billed" or "total charges" for the refraction as \$6.00. The \$6.00 would be denied as non-covered services.

In a follow-up examination where refractive procedures are performed, the value of the refractive procedures, as a percent of the total charges made by the physician, is generally higher. Although professional estimates vary, the most common view is that the refractive procedures represent approximately 33% of the total submitted charge for a follow-up examination. For example, if the sub-

mitted charge for a follow-up examination is \$15.00, the following calculations would be made:

$\$15.00 \text{ multiplied by } 33\% (.333) = \$5.00$

(rounded off to the nearest \$.05)

The charge for the refraction is then \$5.00.

$\$15.00 \text{ minus } \$5.00 = \$10.00$

The submitted charge for the follow-up eye examination is then \$10.00.

The Explanation of Medicare Benefits would show \$10.00 as the "amount billed" or "total charge" for the refraction. The \$5.00 refraction charge would be denied. In cases where a patient has had eye surgery, and the visits are post-operative follow-up care, this should be stated clearly on the claim and the above percentage decrease will not be applicable.

*Physicians are encouraged to separate their charge for refractive procedures themselves. Whenever an initial eye examination or a follow-up visit does not include a refractive procedure, this should be clearly stated on the bill or claim.*

For example:

Initial eye examination—\$30.00

No Refraction

When this information is present, the Medicare carrier will not reduce the charge. In the absence of this information, the carrier must presume that an eye refraction was included in the examination, and reduce the charge accordingly.

## New Laboratory Certifications

Notice was received from the Bureau of Health Insurance, Social Security Administration of the following laboratories approved for participation in the Medicare program.

Recently certified for participation:

Lia Clinical Laboratory  
3617 West Chicago Avenue  
Chicago, Illinois 60651  
Provider Number: 14-8330  
Effective Date: October 26, 1976

Tree Towns Clinical Laboratory, Inc.  
1210 South Garfield  
Lombard, Illinois 60148  
Provider Number: 14-8327  
Effective Date: November 29, 1976

Scientific Medical Laboratory  
3824 North Ashland Avenue  
Chicago, Illinois 60613  
Provider Number: 14-8326  
Effective Date: September 21, 1976

# Abstracts of Board Actions

April 23-27, 1977

Chicago

*These abstracts are published so that members of the Illinois State Medical Society may keep advised of the actions of the Board of Trustees. It covers only major actions and is not intended as a detailed report. Full minutes of the meetings are available upon any member's request to the headquarters office of the ISMS.*

## Cost Containment

The Board of Trustees authorized creation of a task force or study group to address the issue of cost containment in health care. With the data gathered by this study group, ISMS would have the means to:

1. Convince government of the magnitude of its involvement in the escalating costs of health care.
2. Launch a voluntary program of cost containment in Illinois.
3. Resist government cost controls and mandatory cost containment measures.

## Medicaid Problems

In view of the urgent need for Medicaid reform and fee adjustment, ISMS has presented a proposal to Governor Thompson and Acting IDPA Director Quern which calls for:

1. Involvement of physicians by contract at the "front end" of the claims processing system, including processing and peer review of physician claims in conjunction with an automated system installed by Electronic Data Systems—a Texas-based firm currently serving as medical fiscal intermediary in six states.
2. Development of an incentive reimbursement plan that would ensure present payment levels but allow increases based upon savings.
3. Granting physicians a "free hand" to manage the system and bring about reforms—including development of additional access to care to replace Medicaid mills.

The projected costs for physicians' services & those over which MDs exercise direct utilization control—such as drugs, laboratory services & hospital days of care—would be capitated & placed in a physicians' incentive pool. By impacting the system through improved administrative controls & generation of savings in use of services, physicians then would be permitted to draw upon the residue in the incentive pool to provide added compensation up to an agreed upon maximum level of usual, customary & reasonable fees—for example, the 75th percentile of '76 billings.

In other actions involving Medicaid, the Board:

1. Approved suggested revisions in IDPA's Physician Agreement Form.
2. Notified two physicians with Medicaid problems that ISMS cannot assist them if their problems resulted from their own or their hospital's administrative procedures, rather than IDPA policy.
3. Requested IDPA to bring its Medical Handbook for Physicians into conformance with Current Procedural Terminology, Edition IV.
4. Agreed to support a Granite City physician in his fight to prohibit IDPA from suspending or terminating him from the Medicaid program. The physician is challenging IDPA's audit procedures as a denial of his rights to due process.

## Membership Drive

The Board urged all county medical societies to launch membership drives similar to that of the Chicago Medical Society to recruit qualified non-members. To assist county societies in their efforts, ISMS will distribute updated lists of non-member physicians and informational brochures on advantages of membership.

*(Continued on page 475)*

# THE LOWER G.I. TRACT ORGANICALLY SOUND

---



**Celiac angiography** is one of a number of highly specialized diagnostic techniques sometimes necessary to rule out organic causes of abdominal pain.

---



# Editorials



## *The Public Demand—or the Public be Damned?*

We are in an age of consumerism, of accountability, as some have called it. The media is rife with reports of scandal, extortion, gouging, payoffs and other sometimes sensationalized stories. There seems to be an insatiable quest by the citizenry to "gossip," and an activity by the media to build an audience through half-truth and innuendo.

There is an old adage which says "where there's smoke, there's fire." This often proves out in various professions when there are charges of fraud, cheating, incompetence, or other scandalous activity. However, the "proof" usually turns out to be that isolated individuals have acted improperly, are unethical or incompetent, or are guilty of wrongdoing. These individuals, by and large, represent only a very small proportion, probably less than 1%, of the universe being attacked.

Through the media reports, a society of discord, an age of distrust, is being created. This is not to say that accurate, factual reporting is challenged, but rather that the whole picture, including the good news, should be presented on balance.

In the meantime, every profession must gird itself to take strong, appropriate steps to ferret

out those who are less than competent, those who are unethical, those who stigmatize an entire profession. Through internal mechanisms the professions must correct those guilty of wrongdoing, or take steps to see that such persons cannot hurt the profession or the public.

Medicine has a unique obligation to live up to this challenge, since peoples' lives often are at stake. The very moral fiber of the medical profession mandates this, to a greater degree than in almost any other occupation. The alcoholic or other drug addicted physician, the Medicaid rip-off artist, the out-of-date practitioner, and others, must be identified and their practices modified. This must be done internally, guaranteeing due process. Failing this, sanctions by state or federal regulatory or law enforcement agencies may be invoked, with or without the cooperation of the profession.

Whether in an age of accountability or not, this is the nature of professional responsibility.

In medicine, prevention of illness is the first tenet. If there is "some smoke," the profession must act to put out the fire.

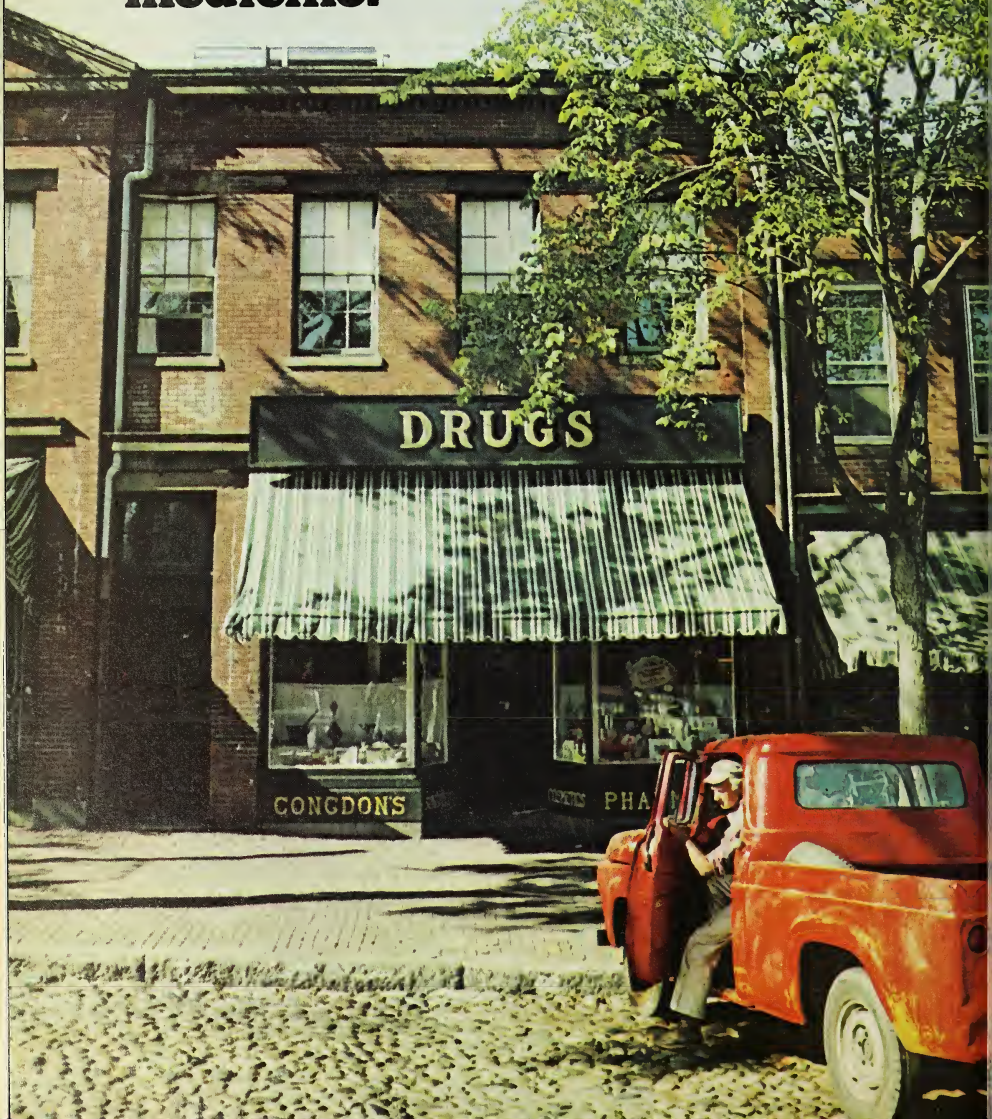
This is the public demand. A public be damned attitude on the part of any member of any profession should not be tolerated.

RO



CIBA nationwide CHEC program reveals\*

**An estimated 13 million  
American hypertensives  
aren't getting their  
medicine.\*1**



## 417



## Vitamin D Poisoning

### From Ingestion of Concentrated Vitamin D Used to Fortify Milk

By TAKEKI HIRANO, M.D., NATESAN JANAKIRAMAN, M.D., AND IRA M. ROSENTHAL, M.D./CHICAGO

*Since the description of hypervitaminosis D was first published in 1928 by Hess and Lewis, numerous reports have appeared.<sup>1</sup> As awareness of toxic effects of excessive vitamin D increased, poisoning became quite uncommon. Almost all cases were due to improper administration of vitamin D preparations obtained at drug stores. We are reporting a patient with hypercalcemia from an extremely unusual source of vitamin D.*

#### Case Report

A 13-year-old black male was admitted to the Department of Pediatrics of the Cook County Hospital because of nausea, vomiting, weight loss and abdominal pain. Anorexia began three weeks prior to admission, followed by vomiting which was associated with vague intermittent abdominal pain. During the week prior to ad-

mission, he started to have severe nausea with frequent emesis and was unable to attend school. He lost 5 kg of weight during this period. Muscle weakness and frequency of urination were noted.

The child's 35-year-old mother was admitted simultaneously with severe abdominal pain, anorexia, vomiting, and weight loss of two weeks' duration.

The patient was thin, moderately dehydrated and appeared chronically ill. His weight was 36 kg (20th percentile) and height 150 cm (50th percentile). His temperature was 37.5 C, respiratory rate 20/min., pulse rate 90/min., and blood pressure 140/96 mm Hg. Skin turgor was poor and buccal mucous membrane was dry. The cornea was clear. The remainder of the physical examination was within normal limits.

Initial biochemistry results showed that BUN was 57 mg/dl, creatinine 3.2 mg/dl, sodium 136 mEq/L, chloride 93 mEq/L, potassium 4.0 mEq/L and bicarbonate 29 mEq/L. Urinalysis showed a trace of protein, 10-20 white blood cells and 10-20 of granular casts per high power field.

---

TAKAKI HIRANO, M.D., is an attending physician in the department of pediatrics of Cook County Hospital and the Hektoen Institute for Medical Research in Chicago.

NATESAN JANAKIRAMAN, M.D., is an assistant professor in the department of pediatrics of the University of Health Sciences/The Chicago Medical School.

IRA M. ROSENTHAL, M.D., is a professor and head of the department of pediatrics, University of Illinois Abraham Lincoln School of Medicine.

CBC was normal. The patient was treated with intravenous fluids. Hydralazine was administered orally for hypertension.

On the second hospital day, hypercalcemia of 13.9 mg/dl was noted. The serum phosphorous was 4.5 mg/dl and the total protein was 7.2 g/dl. Low calcium diet and oral phosphate were started. A repeat serum calcium level was 14.6 mg/dl. He was treated with saline diuresis (4L. of normal saline every 24 hours) and furosemide (40 mg intravenously every 12 hours). Three days later the serum calcium level was 10.2 mg/dl and urinary calcium excretion ranged from 500 to 700 mg per day (normal 80-160 mg per day). Because of a rebound of serum calcium to 12.4 mg/dl following saline diuresis, prednisone 40 mg per day for 7 days was begun. His general condition improved. The blood pressure, BUN and serum creatinine returned to normal.

The mother also had hypercalcemia with normal serum phosphorus level. The hypercalcemia was treated with saline diuresis and intravenous hydrocortisone with a good response.

After careful questioning and numerous denials of exogenous vitamin D administration the mother related that she and eight other members of the family had been taking "a condensed milk" fortifier, "DeViosol", for the past 6 weeks. She suspected that it might have caused her and her son's illnesses because the dog died after drinking this "milk." DeViosol, manufactured by Vitamin Incorporated in Chicago, Illinois, is a form of condensed milk containing a highly concentrated vitamin D. A 155 ml can is used to fortify 16,000 liters of commercial milk. The family members, who were unaware of this product's contents, consumed about 12 cans over 6 weeks. Surprisingly, other family members had normal serum calcium levels. It was not clear how and where this material had been obtained, although they claimed that it was a gift from one of their friends who worked at a warehouse company.

## Discussion

Clinical features of vitamin D intoxication are weakness, weight loss, anorexia, excessive thirst, abdominal pain, nausea, vomiting, constipation, headache, polyuria, hypercalcemia, normophosphatemia, azotemia, and hypercalciuria.<sup>2,3</sup> Since the child had the classic manifestations, vitamin D poisoning was immediately suspected. The diagnosis, however, was difficult because the mother repeatedly denied excessive ingestion of

vitamin D. The possibility of familial hyperparathyroidism was considered, but the normal serum phosphorous in both the patient and mother made this possibility remote. Other cases of hypercalcemia, such as malignant tumors with bony metastasis, tumors producing ectopic parathyroid hormone, sarcoidosis, acute disuse osteoporosis, milk-alkali syndrome, idiopathic hypercalcemia of infancy, hypervitaminosis A, Addison's disease, administration of thiazide diuretics, hypophosphatemia and hyperthyroidism, seemed unlikely with two family members symptomatic at the same time.<sup>4,5</sup> We calculate that each family member might have taken as much as 180,000 units of vitamin D daily. Anning *et al.* have shown that the toxic effects of vitamin D are noticed in daily dosage of 100,000 to 150,000 units, or more than 1,100 units per kg of body weight.<sup>2</sup>

Therapies for hypercalcemia include oral phosphate, low calcium diet, hydration, saline diuresis with or without furosemide, calcitonin, mitramycin, adrenal steroids and intravenous phosphate.<sup>6</sup>

Saline diuresis with intravenous furosemide, suggested by Suki *et al.* and Najjar *et al.*, has been successful in reducing moderate hypercalcemia (12-15 mg/dl).<sup>7,8</sup> A favorable response was obtained by this regimen in our patient, although a rebound of serum calcium developed after discontinuation of furosemide as pointed out by Najjar *et al.*<sup>8</sup> Saline diuresis and/or furosemide increase calcium excretion in urine by producing natriuresis.

Glucocorticoids have been used, as in our case, with beneficial results in pediatric and adult victims of vitamin D poisoning.<sup>3,9,10</sup> The daily dosage has varied from 20 mg of hydrocortisone in infants to 60 mg of prednisone per square meter of body surface area. They can be used for moderate hypercalcemia of other causes than hyperparathyroidism, although they are not effective in acute relief of severe hypercalcemia (more than 15 mg/dl).<sup>11</sup> Their mechanism of action is due mainly to the inhibition of calcium absorption mediated by vitamin D through diffusion and active transport of calcium through the intestine, and to a smaller extent, due to the inhibition of bone resorption.<sup>12</sup>

Calcitonin, secreted by "C" cells of the thyroid, parathyroids and thymus, lowers serum calcium by decreasing bone resorption and increasing calcium excretion in the kidney.<sup>13</sup> Porcine calcitonin and salmon calcitonin were isolated for clinical use, and the former were used by Count



et al., in a pediatric patient with hypervitaminosis D resulting in immediate lowering of serum calcium and a prolonged hypocalcemic effort.<sup>10</sup> Raisz et al. described the synergistic inhibitory effect of bone resorption of glucocorticoids and calcitonin and suggested a clinical use of that combination in a hypercalcemic patient through in-vitro bone culture study.<sup>14</sup>

Mitramycin, an anti-tumor agent, is known to reduce high serum calcium level.<sup>15</sup> But there is little experience in children with this drug. Also one does not want to use mitotic effective drugs for children's diseases that are not life threatening.

Although the most effective means for efficaciously reducing severe hypercalcemia in a short period of time is by phosphate infusion, extensive experience in pediatrics was not available.

Recent studies of vitamin D metabolism have established that vitamin D is hydroxylated in the liver to 25-hydroxy-vitamin D (25OHD), which is transported to the kidney, where 1,25-dihydroxy-vitamin D ( $1,25(\text{OH})_2\text{D}$ ) is produced.  $1,25(\text{OH})_2\text{D}$  is a metabolically active form of vitamin D.<sup>16</sup> Production of the active metabolites is regulated through negative feedback mechanisms by the serum concentration of calcium, phosphorous, parathyroid hormone, 25OHD or  $1,25(\text{OH})_2\text{D}$ .<sup>17</sup> It is shown that the serum level of 25 OHD by a competitive protein-binding assay was markedly elevated in a case of vitamin D intoxication.<sup>10</sup> Measurement of serum 25OHD level would be specific for the diagnosis of hypervitaminosis D as the etiology of hypercalcemia. Unfortunately this test is not readily available.

It is surprising that only two of ten family members developed vitamin D intoxication, though vitamin D intake quantitatively in each individual might have varied. A wide spectrum of sensitivity to vitamin D is well known.<sup>2</sup> Some individuals develop toxicity at 10 times the daily allowance, whereas others tolerate the dose 100 times the daily allowance before hypercalcemia results. This may be related to the sensitivity of negative feedback mechanism or activity of enzymes involving hydroxylation of vitamin D in the liver or kidney. Those who are sensitive to vitamin D, such as patients with sarcoidosis or idiopathic hypercalcemia of infancy, may have impairment of the negative feedback mechanism. As a result, a large amount of active metabolites of vitamin D is produced, regardless of high serum calcium levels.

Our case demonstrates that vitamin D poisoning should remain a primary consideration in any

hypercalcemic child. A negative history of its excessive ingestion is insufficient to rule out this diagnosis and an extremely detailed dietary history should be obtained. This experience emphasizes that there is the need for safety in any commercial operation involving vitamin D preparation used to fortify milk. ◀

## References

- Hess, A. F. and Lewis, J. M.: "Clinical Experience with Irradiated Ergosterol." *JAMA*, 91:783-788, 1928.
- Anning, S. J., Dawson, J., Dolby, D. E. and Ingram, J. T.: "The Toxic Effects of Calciferol." *Quart. J. Med.*, 67:207-228, 1948.
- Vernar, J. V., Engel, F. L. and McPherson, H. T.: "Vitamin D Intoxication: Report of Two Cases Treated with Cortisone." *Ann. Intern. Med.*, 48:765-773, 1958.
- Root, A. W. and Harrison, H. E.: "Recent Advances in Calcium Metabolism. II. Disorders of Calcium Homeostasis." *J. Pediatr.*, 88:177-199, 1976.
- Fisher, G. and Skillern, P. G.: "Hypercalcemia Due to Hypervitaminosis A." *JAMA*, 227:1413-1414, 1974.
- Goldsmith, R. S.: "Treatment of Hypercalcemia." *Med. Clin. North Amer.*, 56:951-960, 1972.
- Suki, W. N., Yuim, J. J., Von Minden, M., Herbert, S. H., Eknoyan, G. and Maldonado, M. D.: "Acute Treatment of Hypercalcemia with Furosemide." *New England J. Med.*, 283:836-840, 1970.
- Najjar, S. S., Afimos, S. F. and Kurani, R. F.: "Furosemide Therapy for Hypercalcemia in Infants." *J. Pediatr.*, 81:1171-1174, 1972.
- Winberg, J. and Zetterstrom, R.: "Cortisone Treatment in Vitamin D Intoxication." *Act. Pediatr.*, 45: 96-101, 1956.
- Counts, S. J., Baylink, D. J., Shen, F. H., Sherrard, D. J. and Hickman, R. D.: "Vitamin D Intoxication in an Aneuphric Child." *Ann. Intern. Med.*, 82:196-200, 1975.
- Dent, C. E. and Watson, L.: "The Hydrocortisone Test in Primary and Tertiary Hyperparathyroidism." *Lancet*, 2:662-664, 1968.
- Harrison, H. E. and Harrison, H. C.: "Transfer of Ca 45 Across Intestinal Wall in Vitro in Relation to Action of Vitamin D and Cortisol." *Am. J. Physiol.*, 199:265-271, 1960.
- Hassman, H.: "Chapter II—Parathyroid Hormone, Calcitonin and Calciferol." Williams, R. E. TEXTBOOK OF ENDOCRINOLOGY, Philadelphia, 5th Edition, 1974.
- Raisz, L. G., Trummel, C. L., Wener, J. A. and Simmons, H.: "Effect of Glucocorticoids on Bone Resorption in Tissue Culture." *Endocrinology*, 90:961-967, 1972.
- Perlia, C. P. and Eidelberg, D.: "Abstract: Mitramycin Treatment of Hypercalcemia." *Ann. Intern. Med.*, 70:1103, 1969.
- DeLuca, H. F.: "The Kidney as an Endocrine Organ for the Production of  $1,25$ -Dihydroxyvitamin D<sub>3</sub>, a Calcium Mobilizing Hormone." *New England J. Med.*, 289:359-365, 1973.
- Root, A. W. and Harrison, H. E.: "Recent Advances in Calcium Metabolism. I. Mechanisms of Calcium Homeostasis." *J. Pediatr.*, 88:1-18, 1976.

## Clinics for Crippled Children

### Listed for July

Twenty-seven clinics for Illinois physically handicapped children have been scheduled for July by the University of Illinois, Division of Services for Crippled Children. The Division will count eighteen general clinics providing diagnostic orthopedic, pediatric, speech and hearing examination, along with medical, social and nursing services. There will be eight special clinics for children with cardiac conditions and one for children with cerebral palsy. Any private physician may refer to or bring to a convenient clinic any child or children for whom he may want examination or consultative services.

- July 1 Division Cardiac, U. of I. at the Medical Center
- July 6 Hinsdale, Hinsdale Hospital
- July 7 Sterling, Community General Hospital
- July 7 Effingham, St. Anthony Memorial Hospital
- July 7 Lake County Cardiac, Victory Memorial Hospital
- July 8 Chicago Heights Cardiac, St. James Hospital
- July 11 Peoria Cardiac, St. Francis Hospital
- July 12 East St. Louis, Christian Welfare Hospital
- July 12 Quincy, St. Mary's Hospital
- July 13 Champaign-Urbana, McKinley Hospital
- July 13 Chicago Heights General, St. James Hospital
- July 13 Joliet, St. Joseph's Hospital
- July 14 Springfield, St. John's Hospital
- July 14 Macomb, McDonough District Hospital
- July 18 Maywood, Loyola Medical Center
- July 19 Belleville, St. Elizabeth's Hospital
- July 19 Rock Island, Moline Public Hospital
- July 19 Decatur, Decatur Memorial Hospital
- July 20 Springfield Pediatric-Neurology, St. John's Hospital
- July 20 Centralia, St. Mary's Hospital
- July 21 Elmhurst Cardiac, Memorial Hospital of DuPage County
- July 22 Chicago Heights Cardiac, St. James Hospital
- July 25 Peoria Cardiac, St. Francis Hospital
- July 26 Park Ridge Cardiac, Lutheran General Hospital
- July 27 Rockford, St. Anthony's Hospital
- July 27 Chicago Heights General, St. James Hospital
- July 27 Elgin, Sherman Hospital

The Division of Services for Crippled Children is the official state agency established to provide medical, surgical, corrective and other services and facilities for diagnosis, hospitalization and after-care for children with crippled conditions or who are suffering from conditions that may lead to crippling. In carrying on its program, the Division works cooperatively with local medical societies, hospitals, the Illinois Children's Hospital-School, civic and fraternal clubs, visiting nurse association, local social and welfare agencies, local chapters of the National Foundation and other interested groups. In all cases the work of the Division is intended to extend and supplement, not supplant activities of other agencies, either public or private, state or local, carried on in behalf of crippled children.

## Do you have patients with Paget's Disease of Bone?



You can get updated information on the disease and on effective treatment for its symptoms of bone pain, skeletal deformities, and neurologic deficits.

Just send the coupon below.



Armour Pharmaceutical Company  
Greyhound Tower  
111 West Clarendon Avenue  
Phoenix, Arizona 85077

- ☐ Send latest information on Paget's Disease of Bone.
- ☐ Have your representative call on me.

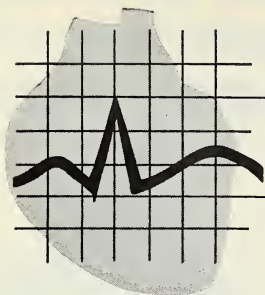
Dr. \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_

State \_\_\_\_\_

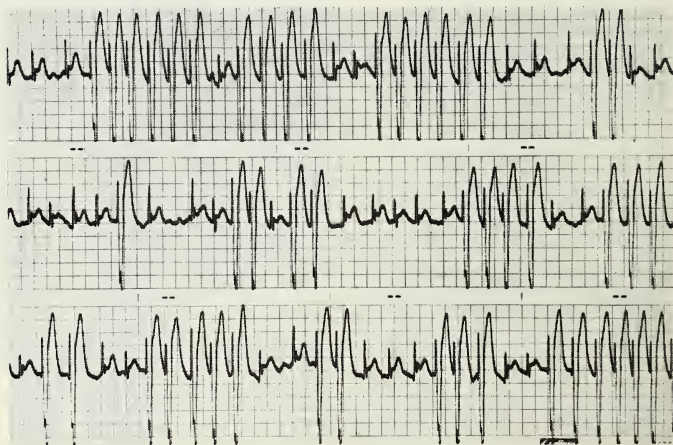
Zip \_\_\_\_\_



## ekg of the month

JOHN R. TOBIN, JR., M.S., M.D., RIMGAUDAS NEMICKAS, M.D.,  
PATRICK J. SCANLON, M.D., JOHN F. MORAN, M.S., M.D.,  
SARAH JOHNSON, M.D., and ROLF M. GUNNAR, M.S., M.D./  
Section of Cardiology, Department of Medicine,  
Loyola University Stritch School of Medicine

This patient is a sixty-year-old man who developed angina pectoris while working in a gas station. The pain gradually increased in frequency and severity until he could no longer work. Even slowly walking one block would bring on the pain. He underwent coronary arteriography which showed three vessel coronary disease and nearly normal left ventricular function. Subsequently, he had open heart surgery and three aorto coronary saphenous vein bypass grafts placed across the obstructed coronary arteries. Post-operatively, he did very well until the fifth day when he developed chest pain and dyspnea. A three component pericardial friction rub was easily heard. This ECG rhythm strip was recorded.



### Questions:

#### 1. The ECG rhythm shows:

- A. Paroxysmal ventricular tachycardia.
- B. Atrial fibrillation with a rapid ventricular response.
- C. ST segment elevation suggesting a current of injury.
- D. Aberrant intraventricular conduction.
- E. Intermittent bundle branch block.

#### 2. Treatment should include:

- A. 100 mgm intravenous lidocaine bolus followed by a lidocaine infusion.
- B. Digitalization.
- C. Temporary pacemaker implantation.
- D. Quinidine orally.
- E. None of the above.

(Answers on page 487)



**contains no aspirin**

tablets

# **Darvocet-N<sup>®</sup> 100**

100 mg. Darvon-N<sup>®</sup> (propoxyphene napsylate)  
650 mg. acetaminophen

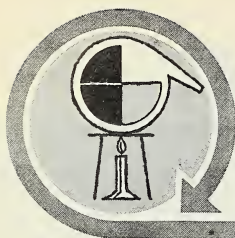


Additional information available to the profession on  
request from Eli Lilly and Company  
Indianapolis, Indiana 46206



Eli Lilly and Company, Inc.  
Carolina, Puerto Rico 00630





# new pharmaceutical specialties

By PAUL DEHAEN

For detailed information regarding indications, dosage, contraindications and adverse reactions, refer to the manufacturer's package insert or brochure.

**New Single Drugs**—Drugs not previously known, including new salts.

**Duplicate Single Drugs**—Drugs marketed by more than one manufacturer.

**Combination Products**—Drugs consisting of two or more active ingredients.

**New Dosage Forms**—Of a previously introduced product.

The following new drugs have been marketed:

## NEW SINGLE DRUGS

**AZANE** Tranquizer Rx  
 Manufacturer: Endo Laboratories, Inc.  
 Nonproprietary Name: Clorazepate Monopotassium C  
 Indications: Symptomatic relief of anxiety  
 Warnings: Those common for benzodiazepine compounds  
 Dosage: 26 mg daily in divided doses, adjust to response of patient  
 Supplied: Capsules, 3.25 and 6.5 mg

**OPTIMINE** Antihistamine Rx  
 Manufacturer: Schering Laboratories  
 Nonproprietary Name: Azatadine Maleate  
 Indications: Perennial and seasonal allergic rhinitis and chronic urticaria  
 Contraindications: See package insert  
 Dosage: 1 to 2 mg twice a day, adjust to response of patient

## BIOLOGICAL

**MENOMUNE-A Vaccine** Biological Rx  
 Manufacturer: Merrell-National  
 Nonproprietary Name: Meningococcal Polysaccharide Vaccine, Group A  
 Indications: Protection against infections caused by *N. meningitidis*, Group A  
 Immunizing Dose: 0.5 mg/50 mcg  
 Supplied: Vials, active ingredient with diluent.

## DUPLICATE BIOLOGICAL

**MENOMUNE-C Vaccine** Biological Rx  
 Manufacturer: Merrell-National

Nonproprietary Name: Meningococcal Polysaccharide Vaccine, Group C  
 Indications: Protection against infections caused by *Neisseria meningitidis*, Group C  
 Immunizing Dose: 0.5 ml/50 mcg  
 Supplied: Vials, active ingredient with diluent.

## COMBINATION PRODUCTS

**Riopan Plus** Antacid-Antiflatulent o.t.c.  
 Manufacturer: Ayerst Laboratories  
 Composition: Magaldrate 400 mg  
 Simethicone 20 mg  
 Indications: Relief of heartburn, acid indigestion, sour stomach  
 Dosage: One or two teaspoonfuls between meals and at bedtime  
 Supplied: Bottle, 12 fl oz.

## NEW DOSAGE FORMS

**DIPROSONE Lotion 0.05%** Corticoid Local Rx  
 Manufacturer: Schering Laboratories  
 Nonproprietary Name: Betamethasone Dipropionate  
 Indications: Inflammatory manifestations of corticosteroid responsive dermatoses  
 Administration: Apply a few drops of lotion to affected area  
 Supplied: Plastic squeeze bottles, 20 ml/18.7 g and 60 ml/56.2 g (0.05 per cent)

**SOMOPHYLLIN Capsules** Antiasthmatic Rx  
 Manufacturer: Fisons Corporation  
 Nonproprietary Name: Theophylline  
 Indications: Symptomatic relief of bronchial asthma, pulmonary emphysema, chronic bronchitis and other pulmonary diseases associated with bronchospasm.  
 Warnings: Use with caution in severe hypertension and young children and infants  
 Dosage: Adjust to patient's response  
 Adults: 200 to 250 mg every six hours  
 Children over four years: 100 mg per 40 lbs every six hours  
 Supplied: Capsules, 3.25 and 6.5 mg

**Business Essentials for a Medical Office**

one-day workshop for your medical office assistants

**9 AM to 5 PM**

July 26, 1977	Evanston	Holiday Inn
July 27, 1977	Chicago	Palmer House
July 28, 1977	Chicago	Palmer House
July 29, 1977	Joliet	Sheraton Inn
August 3, 1977	Rockford	Clock Tower Inn
August 4, 1977	Peoria	Hilton
August 5, 1977	Springfield	State House Inn

TOPICS: Telephone Management, Appointment Scheduling, Medical Records, Personnel, Billing Systems and Collection, Insurance Claim Processing.

**Practice Productivity Inc.** is a national management consulting firm located in Atlanta. Physicians are engaged in the private practice of medicine. Practice Productivity offers educational and motivational workshops in sound business concepts to physicians, medical office managers, and medical assistants. It also provides in-depth, on-premise consulting to physicians.

For further information, contact Duane M. Johnson, Ph.D., Executive Vice-President, Practice Productivity Inc., telephone 404/455-7344, or toll free Registration Desk 800/241-6228.

**Registration Form**

Please register the following persons (type or print)

Name

Position

Date Will Attend

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_

From the office of:

Name \_\_\_\_\_ Specialty \_\_\_\_\_ Telephone: (\_\_\_\_) \_\_\_\_\_

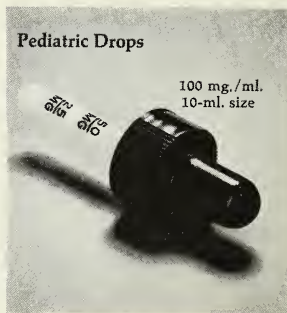
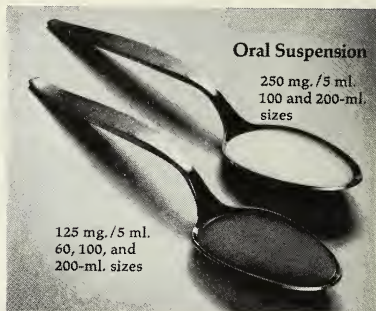
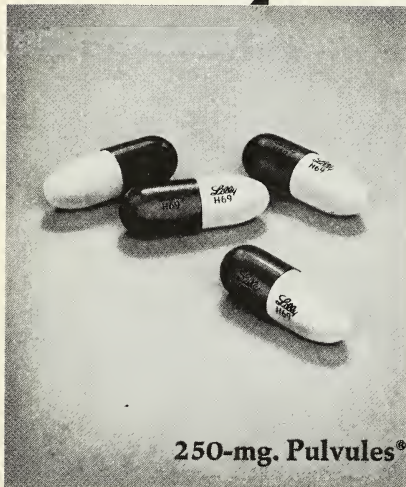
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Full tuition fee of \$\_\_\_\_\_ is enclosed at \$75 per registrant. Tuition includes course materials and luncheon and **MUST ACCOMPANY THIS FORM**. (There is a \$10 handling fee deducted on all refunds for cancellations received at least one week in advance of course; no refund thereafter.)

Make check payable and mail to:

**Practice Productivity Inc.** 2000 Clearview Avenue, Atlanta, Georgia 30340

# easy to take



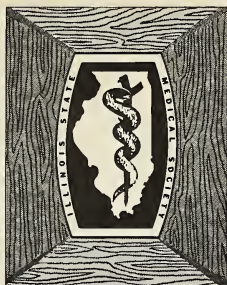
## Keflex®

cephalexin



500738

Additional information available to the profession on request.  
Eli Lilly and Company  
Indianapolis, Indiana 46206



# I M J

Illinois Medical Journal

Vol. 151, No. 6, June, 1977

## Ultrastructure of Skeletal Muscle in a Case of Malignant Hyperpyrexia

JOSE J. NAVAS, M.D./MADRID, SPAIN

*A case of malignant hyperpyrexia, in a four-year-old child who underwent surgery under general anesthesia (Halothane®), is reported. Strongly PAS-positive diastase resistant material was present in the perinuclear and subsarcolemmal regions of the muscle fibers of the right vastus lateralis. Electron microscopic study revealed crystalline structures composed of parallel arrays of dense granules measuring 180 Å in diameter. The distribution was the same as the PAS-positive material seen under light microscopy. The crystalline-structures could be the manifestation of a subclinical myopathy.*

Malignant hyperpyrexia is a syndrome consisting of rapid, progressive rise in body temperature during general anesthesia. Metabolic acidosis and electrolyte imbalance develop rapidly. The terminal stage is characterized by temperatures of 42°C and higher, hypoxemia, hypercarbia and ventricular dysrhythmias progressing to cardiac arrest.

The incidence is estimated to be about 1:100,000

general anesthetic procedures. The mortality of those developing the syndrome is between 60 and 70%. The pathogenesis is unknown.

This report presents a case of malignant hyperpyrexia with morphologic abnormalities in the skeletal muscle with light and electron microscopy.

### Report of Case

Patient was admitted to Evanston Hospital for correction of right clubfoot. He was the product of a normal gestation and delivery, but was born with a right clubfoot and casting was performed immediately. At one year of age, because of persistence of the malformation, lengthening of the right Achilles tendon and posterior capsulotomy were performed. For this, he was premedicated with atropine (0.2 mg) and Demerol® (10 mg); Ketamine® was given as anesthetic agent, total dosage 150 mg. The rectal tempera-



JOSE J. NAVAS, M.D., was a resident in pathology affiliated with the Northwestern University Medical School and the Evanston Hospital department of pathology and laboratory medicine at this writing. He is a member of the Spanish Society of Anatomic Pathology, the Illinois Registry of

Anatomic Pathology and a junior member of the American Society of Clinical Pathologists.



tures during the procedure were between 37.1 and 37.4°C. The postoperative recovery was uneventful.

Three years later he was readmitted for a second capsulotomy. Prior to surgery, the laboratory data were normal, except for mild microcytic anemia. For surgery he was premedicated with atropine (0.3 mg) and Demerol® (20 mg). General anesthesia consisted of nitrous oxide and Halothane® plus 20 mg of succinylcholine as muscle relaxant. During surgery, two hours after the initiation of anesthesia, the rectal temperature rose to 42°C. At that time the operation had almost been completed and during closure temperature was lowered with ice packs. However, acidosis, hypercarbia and hypoxemia developed rapidly. There were several episodes of cardiac arrest, and the patient expired eight and one half hours after the anesthesia was begun.

Postmortem electrophoresis of the patient's hemoglobin revealed a pattern consistent with AC hemoglobinopathy, which explains the child's hypochromic anemia. Creatine phosphokinase (CPK) isoenzymes were determined in blood samples taken during surgery. Total CPK was 100 I.U. (Normal 5-50 I.U.), 90% corresponded to the fraction CPK<sub>1</sub> (MM), 10% to CPK<sub>2</sub> (MB). CPK<sub>3</sub> (BB) isoenzyme was undetectable.

At autopsy no abnormalities were recognized in the viscera or brain. The skeletal muscle is described below.

### Material and Methods

**Light microscopy:** Specimens were obtained from the right vastus lateralis and diaphragm 11 hrs. postmortem and fixed in 10% buffered formalin. After fixation, longitudinal and trans-

verse sections were processed by conventional methods and embedded in paraffin. Sections were stained with hematoxylin and eosin, Masson's trichrome, phosphotungstic acid hematoxylin, PAS and D-PAS techniques.

**Electron microscopy:** Samples of right vastus lateralis and diaphragm were studied. Tissue prepared for electron microscopy was minced, and fixed in 2% glutaraldehyde in 0.2M cacodylate buffer. The pieces were transferred to 0.2M cacodylate buffer after 2 hours. The tissue was postfixed in osmium tetroxide, dehydrated in a series of graded alcohol and embedded in Epon. Ultrathin sections were obtained on a MT<sub>1</sub> ultramicrotome, placed on parlodion-coated copper grids and stained with uranyl acetate and lead citrate. Sections were viewed and photographed in a Siemens Elmiskop 101.

### Results

**Light microscopy:** Transverse sections of the right vastus lateralis stained with hematoxylin and eosin showed moderate differences in the diameter of the fibers. The longitudinal sections did not reveal any abnormalities. Preparations stained with PAS demonstrated a strongly PAS-positive granular material in many fibers. That material was resistant to diastase digestion. It was located in the subsarcolemmal and perinuclear regions, although small clumps were present throughout the sarcoplasm. It appeared to be round or oval in the transverse sections and rod-like in the longitudinal sections (Fig. 1). This granular material was less prominent with hematoxylin and eosin, Masson's trichrome and PTAH stains. These inclusions were also seen in the muscle spindles. The blood vessels and interstitium were normal. The sections of

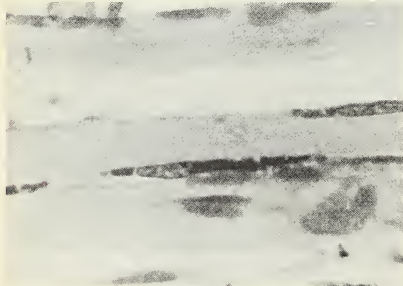


Figure 1

Large perinuclear PAS-positive diastase resistant inclusion in a skeletal muscle fiber (right vastus lateralis). (Diastase-PAS).



Figure 2

Subsarcolemmal collection of elongated crystalline particles. (Uranyl acetate-lead citrate).

the diaphragm did not show these findings.

**Electron microscopy:** Sections of the right vastus lateralis showed numerous cytoplasmic inclusions in most of the fibers. The inclusions were frequently seen in the subsarcolemmal (Fig. 2) and perinuclear regions, and they were also found elsewhere in the sarcoplasm, occasionally related to the Z-bands. The inclusions consisted of electron dense material with an internal crystalline array. The particles could be seen scattered throughout the sarcoplasm or in clusters. The shape was variable: triangular, rhomboidal and elongated configurations were present, with sizes ranging up to 3.5 microns. Some clusters measured 35 microns in the largest dimension. Close observation of the crystalline structures revealed parallel arrays of dense granules approximately  $180 \text{ \AA}$  in diameter (Figs. 3 and 4). The line-to-line distance was  $205\text{--}225 \text{ \AA}$ . The distance between the center of the dense granules was  $260 \text{ \AA}$  along each line.

There were occasional widening and streaming of the Z-bands. The myofibrils were spaced more widely than usual, and the mitochondria showed postmortem changes.

No changes were seen in the blood vessels or in the interstitium. The sections of the diaphragm were essentially normal.

### Discussion

Denborough and Lovell (1960)<sup>2</sup> reported ten cases of unexpected death in 24 members of a family exposed to general anesthesia. High body temperatures were registered in the fatal cases. This complication of general anesthesia followed a pattern of inheritance compatible with an incompletely penetrant autosomal dominant

gene.<sup>2-4</sup> Halothane® and succinylcholine are the drugs most frequently associated with the production of the syndrome. It has been postulated<sup>5-7</sup> that under the action of these agents, muscle susceptible to malignant hyperpyrexia is less capable of storing calcium within the sarcoplasmic reticulum. As a consequence, the muscle remains in a contracted state and inefficient heat-producing metabolism follows.

The association of myopathy with malignant hyperpyrexia was established on clinical and biochemical bases.<sup>8-12</sup> Britt and Kalow<sup>8</sup> found two groups of patients: those characterized by rigidity and those without rigidity during the hyperthermic episode. In the former group there was positive correlation with preexisting musculoskeletal malformations. The finding of raised serum CPK levels in patients and relatives suggested that malignant hyperpyrexia occurs in individuals with an underlying congenital myopathy.<sup>9-12</sup> From the clinical point of view, patients at risk fall into three groups, with absent, slight or manifest myopathy.<sup>4</sup> Patients with overt myopathy and muscular dystrophy have never been reported to suffer this complication of general anesthesia.<sup>13</sup>

The morphologic findings in the skeletal muscle vary according to different authors. Most of the studies have been done with light microscopy in susceptible relatives of patients with malignant hyperpyrexia. The skeletal muscle is normal or with mild non-specific changes in those cases.<sup>9,13-22</sup> Histochemical studies<sup>17-19,23,24</sup> have produced different results: Denborough et al<sup>23</sup> described the presence of a "central core" in 50% of Type I muscle fibers. Harriman et al,<sup>15</sup> observed the same pattern, but described it as

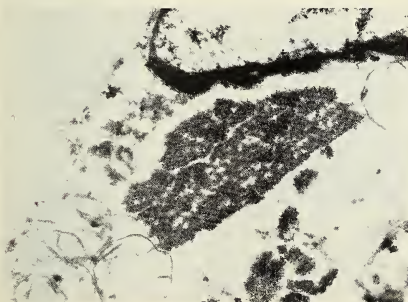


Figure 3

Parallel array of dense granules, period  $220 \text{ \AA}$  (Uranyl acetate-lead citrate).

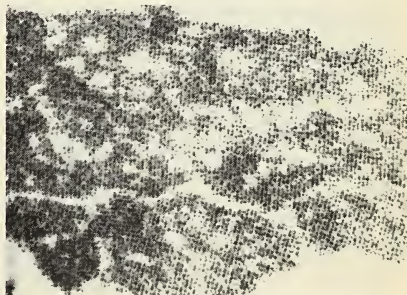


Figure 4

Dense granules measuring  $180 \text{ \AA}$  in diameter are registered in parallel lines. (Uranyl acetate-lead citrate).

"moth-eaten fibers," and postulated that focal areas of absence of mitochondria are relatively common in neuromuscular disease and are not specific for malignant hyperpyrexia.

There are few studies of the skeletal muscle in fatal cases or survivors of malignant hyperpyrexia.<sup>15,24-26</sup> Harriman et al.<sup>15</sup> reported their results in two survivors; the light microscopy, histochemical and ultrastructural studies showed mild non-specific changes. Schiller<sup>24</sup> observed abnormal distribution of ATPase in the muscle of patients who had malignant hyperpyrexia and members of their families. The same author<sup>25</sup> found crystalline inclusions with similar characteristics to those described here in two fatal cases of malignant hyperpyrexia; these inclusions were absent in a survivor. Similar crystalline structures were also seen by Isaacs and Heffron<sup>19</sup> in the perinuclear region of the skeletal muscle fibers in two carriers of the syndrome.

A similar syndrome has been described in certain strains of pigs (Landrace, Poland-China).<sup>27,28</sup> However, ultrastructural studies of the skeletal muscle in these animals showed no specific features.<sup>28</sup>

The meaning of these crystalline structures is obscure. Periodical arrangement of dense granules of similar dimensions have been found in normal skeletal muscle,<sup>29,30</sup> and in skeletal muscle following heat stroke.<sup>31</sup> Recently Schiller<sup>32</sup> suggested that in heat stroke as well as in malignant hyperpyrexia the crystalline structures could conceivably result from precipitation of some material by heat. In relation with the studies of Tang,<sup>33</sup> Schiller also raised the possibility that malignant hyperpyrexia could result from an underlying subclinical chronic viral myopathy.

The existence of parallel arrays of dense granules can be the manifestation of changes in the contractile proteins, like those described in "nemaline myopathy";<sup>34,35</sup> however "nemaline bodies" are clearly related to Z-bands. Such an association is not evident in our case. Nemaline bodies are present in several conditions: early and late "nemaline myopathy," acute psychotic attacks,<sup>36</sup> post-tenotomy,<sup>37</sup> etc. For that reason they are considered a response to different types of injury. Tropomyosin crystals can also produce a similar kind of lattice.<sup>35,38</sup>

### Summary

It is therefore possible that the different types of crystals described in the literature, associated

with a variety of conditions, represent different materials.

The presence of such crystalline structures in asymptomatic carriers of malignant hyperpyrexia,<sup>19</sup> could be the indication that they are not the product of heat precipitation, but the manifestation of a subclinical myopathy. No inclusions were seen in the sample from the diaphragm in our patient. These data also suggest that the inclusions are not produced by generalized precipitation by heat, and it is in favor of a genuine myopathy. ◀

### Acknowledgments

The author thanks Dr. H. H. R. Friederici for the review of the manuscript.

### References

A complete list of references for "Ultrastructure of Skeletal Muscle in a Case of Malignant Hyperpyrexia" may be obtained by writing the *Illinois Medical Journal*, 55 E. Monroe St., Suite 3510, Chicago, IL 60603.

### Ravenswood Hospital Medical Center Director Family Practice Center

Ravenswood Hospital Medical Center is a 450-bed community teaching hospital, affiliated with the Abraham Lincoln School of Medicine of the University of Illinois College of Medicine. The recent approval of its Internal Medicine Residency and its Continuing Medical Education Program are just two indications of Ravenswood's deep commitment to medical education.

The Medical Center and the Ravenswood Family Practice Center, a not-for-profit Corporation, in cooperation, are planning a Family Practice Residency Program. The Director we are seeking will take an active part in the development and execution of plans leading to accreditation of the program by the Liaison Committee on Medical Education. He will then assume overall responsibility for the program.

Qualifications for this position, available immediately, include: experience in primary care, board certification (preferably in FP), experience in medical education and demonstrated administrative ability. The Center offers a competitive salary and benefit program to qualified applicants. Please submit resumes in confidence to: Joseph Schifano, M.D., Chairman, Family Practice Steering Committee, 4550 North Winchester, Chicago, Illinois 60640. Tel: 878-4300, ext. 238



# Anomalous Origin of the Left Coronary Artery from the Main Pulmonary Artery

By B. AGARWALA, M.D., R. AGARWALA, M.D., W. THOMAS, JR., M.D.  
AND S. BHARATI, M.D./CHICAGO

The origin of the left coronary artery from the pulmonary artery was first described anatomically by Brooks<sup>1</sup> in 1886. The clinical features of this anomaly were described by Bland, White, and Garland in 1933.<sup>2</sup> According to Keith<sup>3</sup> the incidence of this anomaly is 1 in 300,000 children and only 15% survive to adult life. The mechanism which makes survival to adult life possible is the development of a large collateral circulation between the right and the left coronary artery so that the right coronary artery is able to perfuse both ventricles.<sup>4</sup> In this paper we present a case of anomalous origin of the left coronary artery which resulted in congestive heart failure in early life. We also emphasize the differential diagnostic criteria of congestive heart failure in infancy from bronchiolitis. The different origins of the coronary arteries with their clinical manifestation, hemodynamic changes, and management methods are also discussed.

## Case History

The patient was a six-week-old black female infant, the product of a normal full-term pregnancy and delivery. Her nursery course was normal. At home she was doing well until the present admission. One day before admission she developed cough, cold, feeding problems and breathing difficulties. There was a strong family history of bronchial asthma.

On physical examination, she was a well developed, well nourished, and irritable infant in respiratory distress with intercostal and substernal retractions. Her body weight was 4500 gms and height was 52.5 cm on admission. The heart rate was 180/min with the respiratory rate of 60/min and rectal temperature of 35.6°C. On auscultation of the lungs, air-entry was good with bilateral wheezing and transmitted inspiratory sounds from the upper respiratory tract. Abdominal examination revealed a palpable liver of 3 cm below costal margin at the right mid-clavicular line. Her peripheral pulses were felt

BROJENDRA AGARWALA, M.D., is an Assistant Professor of Pediatrics, Rush Medical School and Attending Physician in Pediatrics at Mt. Sinai Hospital where he specializes in Pediatric Cardiology. He is a Fellow of the American Academy of Pediatrics and has published several articles.



RITA AGARWALA, M.D., is a first year resident in Radiology at Mt. Sinai Hospital. She is interested in doing research work in Nuclear Medicine.



SAROJA BHARATI, M.D., is associate director of the Congenital Heart Disease Research and Training Center at the Hektoen Institute for Medical Research. A specialist in cardiology, the pathology of congenital heart disease and the conduction system, Dr. Bharati has been the recipient of numerous awards.

WILLIAM THOMAS JR., M.D., is an associate professor of pathology at Rush-Presbyterian-St. Luke's Medical School and also associate director and vice chairman of the department of pathology at Mt. Sinai Hospital.



in all extremities. Cardiac examination was insignificant except for the presence of tachycardia. No heart murmur was heard. There was no evidence of cyanosis. The patient was treated symptomatically with oxygen and high humidity and her condition improved temporarily. Later, she developed increased tachycardia, tachypnea, bilateral rales over both lung bases with abdominal distension. This was followed by cardiorespiratory arrest and she could not be resuscitated.

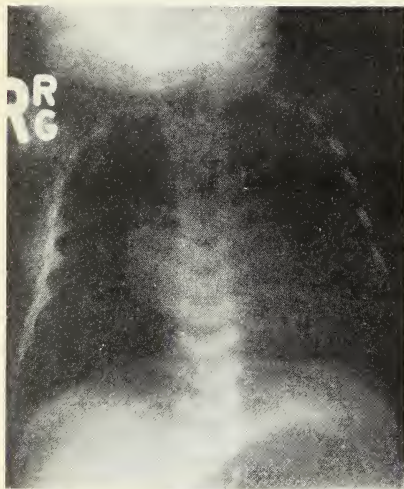


Figure 1

Chest X-ray in postero-anterior view shows enlarged heart with left ventricular enlargement. Pulmonary vascularities could not be evaluated from this print.

#### Laboratory Data

Complete blood count revealed hemoglobin of 12.3 gm%, hematocrit 35%, WBC 13,000 cmm, Poly 40%, Stabs 1%, Eosinophil 3%, lymphocytes 50% and Monocytes 6%. Sick cell preparation was negative. Urinalysis was normal and the throat culture did not grow any pathogenic organisms. Chest X-ray (Fig. 1) showed cardiomegaly with bilateral air trapping, and there was no infiltration in the lungs. Arterial blood gases at room air were as follows: Ph 7.25,  $PO_2$  48 mm Hg,  $PCO_2$  45 mm Hg. The electrocardiogram (Fig. 2) showed evidence of left ventricular hypertrophy with T-wave changes.

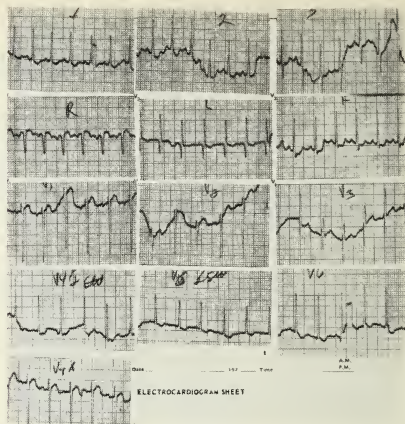


Figure 2

Electrocardiogram: Shows evidence of severe left ventricular hypertrophy for 6 week old baby. Abnormal T wave in I, II, aVF and all over the precordial leads (prior to digitalis). Also note deep q in AVL.

#### Autopsy

Pathologic diagnoses were made in addition to the findings in the heart. Lungs were the seat of diffuse congestion and interstitial pneumonia. The liver, spleen and kidneys were congested. The ovaries were slightly enlarged and contained multiple follicular cysts.

#### Heart

The heart was greatly enlarged, weighing 50 gms. All chambers were hypertrophied and enlarged, especially the left atrium and left ventricle. The endocardium of the left ventricle showed marked fibroelastosis. The latter did not involve the mitral or aortic valves.

The left coronary ostium was not present in the aortic left sinus of Valsalva. Instead it arose from the pulmonary left posterior sinus of Valsalva (Fig. 3). This then gave off the left main coronary artery which divided into the left anterior descending and left circumflex coronary arteries. The right coronary ostium was in the normal aortic right sinus of Valsalva (Fig. 4). It gave off the right main coronary artery in the usual manner, and formed the posterior descending. There were communications between the anterior descending and the acute marginal artery coming from the right coronary artery. The



**Figure 3**

Autopsy specimen of the heart: The main pulmonary artery is noted to be originating from the right ventricle. The arrow is pointing to the ostium of the left coronary artery originating from the main pulmonary artery.

myocardium on histologic examination showed fibrosis and calcification (Fig. 5).

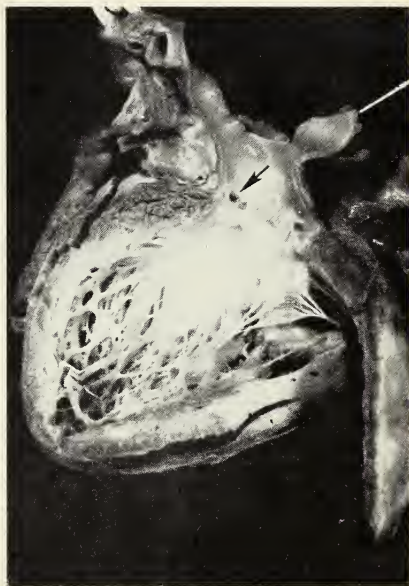
### Discussion

Anomalies of the coronary arteries are not infrequent types of congenital malformation. Some of these must be kept in mind by all pediatricians in order to make an early diagnosis. Not all types of anomalies of the coronary arteries are fatal or of hemodynamic importance. The various types of congenital anomalies that have been described in the literature include the following.

**1. Single coronary artery originating from the aorta:** In this malformation either the right or the left coronary artery arises from the aorta and follows the course of one or both arteries. This anomaly may be associated with other congenital malformations, e.g., truncus arteriosus, transposition of great vessels, etc. There are no

specific symptoms, electrocardiographic changes or chest X-ray findings to make a definite diagnosis of this malformation. Patients have been reported to have died from myocardial infarction<sup>5</sup> in these cases. Smith<sup>6</sup> in his review of single coronary artery reported that 2/3 of the cases have been found in adults dying of other illnesses and in 1/3 of the cases (14 of 45) the lesion was found in children dying with associated congenital heart disease or from respiratory tract infections. In 1965 Hallman et al<sup>7</sup> reported surgical management of a case in which a single coronary artery formed a fistula to the right ventricle.

**2. Origin of the anterior descending coronary artery from the right coronary artery:** This type of anomalous origin of the coronary vessel is associated with Tetralogy of Fallot. This anomaly does not interfere with myocardial perfusion or hemodynamics of the heart. However, this anomaly has a tremendous importance to the surgeon during complete repair of the Tetralogy



**Figure 4**

Autopsy specimen of the heart: The left ventricle with the aorta. The left ventricle is dilated and hypertrophied. The endocardium shows evidence of thickening. The arrow points to the ostium of the right coronary artery arising from the aorta.

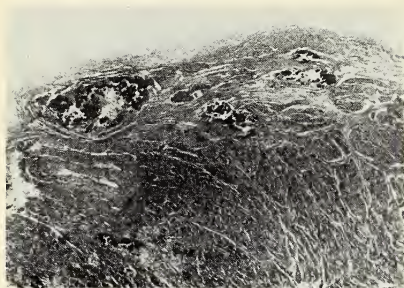


Figure 5

The microscope section of the heart shows fibrosis (pale stained areas) and the black foci represent calcification of the heart.

of Fallot. The course of this vessel is abnormal on the anterior surface of the right ventricle and thereby interferes with the right ventriculotomy incision.

**3. Origin of both coronary arteries from the pulmonary trunk:** This anomaly is almost incompatible with life. This group of infants does not survive more than a week or two. As soon as the pulmonary vascular resistance drops, the myocardium is not perfused and the infant dies from myocardial ischemia and congestive heart failure. Robert<sup>8</sup> in 1962 reported cases with anomalous origin of both coronary arteries from the pulmonary artery.

**4. Origin of the right coronary artery from the pulmonary artery:** Children with this anomaly may remain asymptomatic and the diagnosis is made incidentally during cardiac surgery or during autopsy after they had died from unrelated causes. The direction of blood flow<sup>9</sup> is from the aorta through the normal left coronary artery and its collaterals to the right coronary artery which drains into the main pulmonary artery. Usually the myocardial perfusion is maintained and they do not develop any problems in childhood. There are no typical symptomatologic, physical, electrocardiographic or radiological findings to make a definitive diagnosis. The surgical management is debatable, but some recommend ligation of the right coronary artery.

**5. Anomalous origin of the left coronary artery from the pulmonary artery:** In this anomaly the left coronary artery originates from the left sinus of Valsalva of the pulmonary trunk. The course and distribution of this artery remains normal. Clinically, when it presents in infancy it is very important to make a diagnosis.

Since it may produce symptoms in infancy, the electrocardiographic and radiographic findings are very helpful for diagnosis and these infants could be helped by recent advances in surgery.

A few other rare anomalous origins of the coronary arteries, (e.g. accessory coronary artery) have been described in the literature, but none of them are of significant clinical importance.

#### *Clinical features of origin of left coronary from pulmonary artery*

Most patients with anomalous origin of the left coronary artery from the pulmonary artery are symptomatic during infancy. They usually present with crying during feeding ('colicky baby') as if in pain, with pallor and mild degree of cyanosis. Just like adult anginal pain on exertion, these infants present with the above manifestations during feeding which is an exertion to infants. Some children may present with dyspnea with intercostal retraction, tachypnea, tachycardia, restlessness, wheezing, enlarged liver and poor blood gases. Death may occur suddenly during these episodes.

#### *Physical examination*

Evidence of congestive heart failure is present. There is usually no heart murmur. If a murmur is present it is secondary to mitral insufficiency from dilatation of the heart or from papillary muscle necrosis. Sometimes a continuous heart murmur has also been reported. The heart sounds usually remain normal. Cardiomegaly is always present and detected both clinically and also by chest X-ray. Electrocardiogram is very characteristic. It usually shows myocardial infarction pattern. Sometimes left ventricular hypertrophy pattern is noted from increased posterior forces because of loss of anterior forces. Cardiac catheterization confirms the diagnosis by evidence of left to right shunt at the pulmonary arterial level and also by angiographic demonstration of the anomalous origin of the left coronary artery from the pulmonary artery.

#### *Mechanism leading to congestive heart failure in origin of left coronary from pulmonary artery*

In patients with anomalous origin of the left coronary artery from the pulmonary artery the clinical problem arises due to low perfusing pressure in the coronary arteries. During the fetal or very early neonatal period, pulmonary arterial pressure is high because of high pulmonary vascular resistance. This high pulmonary arterial pressure is adequate to supply oxygen demand



for the heart. At approximately eight weeks of life the pulmonary arterial pressure usually drops significantly and decreases coronary perfusion. The myocardium thus suffers from ischemia. Some infants may develop collateral circulation between the right and the left coronary artery and thereby maintain the coronary perfusion from the right coronary artery. Another group of infants with good collateral circulation between the right and the left coronary artery may just shunt the blood through the large collateral vessels without properly perfusing the myocardium and they develop congestive heart failure.

### Differential Diagnosis From Bronchiolitis

We would like to point out that it is very important for a pediatrician to keep this entity in mind when he evaluates a baby with bronchiolitis. During infancy bronchiolitis is one of the major causes of hospitalization. Clinically, to differentiate congestive heart failure from bronchiolitis is very difficult (see Table). Sometimes the electrocardiogram and chest X-ray can be of help in differentiating these two conditions. Presence or absence of a heart murmur may not help to make a diagnosis of congestive heart failure.

### Surgery

Various surgical corrective procedures have

been performed. Cooley et al<sup>10</sup> reported surgical reconstruction of a two-coronary artery system by transplanting the left coronary artery into the aorta. Simple ligation of the left coronary artery also has been tried, if the patient had good collateral circulation from right to the left coronary artery. This procedure helps in retrograde perfusion of the left coronary artery. Saphenous venous graft from aorta to the left pulmonary artery and ligation of the anomalous left coronary artery proximal to the anastomosis has also been done successfully.

In 1970 Wright et al<sup>11</sup> discussed the role of physiologic shunt between the right coronary artery and the main pulmonary artery via the left coronary artery. They described two cases where the left coronary artery steals blood from the right coronary artery to the main pulmonary artery without perfusing the myocardium. These two cases improved by ligation of the anomalous left coronary artery at its origin from the pulmonary artery.

We would like to emphasize that the recognition of this entity is very important in infancy. The physician should keep this entity in mind when dealing with a colicky infant or in infants with respiratory distress. With the recent advancement of technology and knowledge of medicine, these groups of infants could be helped. ◀

TABLE

#### CLINICAL DIFFERENTIAL DIAGNOSTIC CRITERIA FOR BRONCHIOLITIS AND CONGESTIVE HEART FAILURE

	<i>Congestive Heart Failure</i>	<i>Bronchiolitis</i>
Age of onset	Any age	Two months to 1 year
Family history of		
—bronchial asthma	Not present	May be present
—congenital heart dis.	May be present	Not present
Preceding history of cold	Usually not present	Always present
Breathing difficulties	Moderate to severe	Moderate to severe
Tachypnea	Severe	Severe
Chest retraction	Moderate	Severe
Cyanosis or pallor	May be present	Usually present
Tachycardia	Severe	Mild to moderate
Heart sounds	Muffled	Faint
Heart murmur	May or may not be present	Not present
Peripheral pulses	Weak or absent	Easily palpable
Liver enlargement	Moderate to marked	Mild
Lungs	Rales predominately	Wheezing predominately
X-ray chest	Enlarged heart with pulmonary vascular congestion	Normal heart size with normal or decreased pulmonary vasculature
Electrocardiogram	Always abnormal for age	Usually normal for age
Oxygen + humidity	May help very little	Usually helps
Digitalis and Diuretics	Help	Does not help



## References

1. Brooks, H., St. John: "Two Cases of Abnormal Coronary Artery of the Heart Arising from the Pulmonary Artery," *J. Anatomy and Physiol.*, 20:26, 1886.
2. Bland, E. F., White, P. D. and Garland, J.: "Congenital Anomalies of the Coronary Arteries: Report of an Unusual Case Associated with Cardiac Hypertrophy," *Am. Heart J.*, 8:787, 1933.
3. Keith, J. D.: "The Anomalous Origin of the Left Coronary Artery from the Pulmonary Artery," *Brit. Heart J.* 21:149, 1958.
4. Hudson, R. E. B.: *CARDIOVASCULAR PHYSIOLOGY*. Edward Arnold, London, 1965.
5. Roberts, J. T., and Loube, S. D.: "Congenital Single Coronary Artery in Man," *Am. Heart J.*, 34:188, 1947.
6. Smith, J. C.: "Review of Single Coronary Artery with Report of Two Cases," *Circulation*, 1:1168, 1950.
7. Hallman, G. L., Cooley, D. A., MacNamara, D. G. and Latson, J. R.: "Single Left Coronary Artery with Fistula to Right Ventricle; Reconstruction of Two Coronary Systems with Dacron Graft," *Circulation*, 32:293, 1965.
8. Roberts, W. C.: "Anomalous Origin of Both Coronary Arteries from the Pulmonary Artery," *Am. J. Cardiol.*, 10:595, 1962.
9. Rowe, G. G. and Young, W. P.: "Anomalous Origin of the Coronary Arteries with Special Reference to Surgical Treatment," *J. Thoracic Cardiovasc. Surg.*, 39:777, 1960.
10. Cooley, D. A., Hallman, G. S. and Bloodwell, R. D.: "Definitive Surgical Treatment of Anomalous Origin of Left Coronary Artery from Pulmonary Artery; Indications and Results," *J. Thoracic Cardiovasc. Surg.*, 52:798, 1966.
11. Wright, N. L., Baue, A. E., Baum, S., Blakemore, W. S. and Zinsser, H. F.: "Coronary Artery Steal Due to an Anomalous Left Coronary Artery Originating from the Pulmonary Artery," *J. Thoracic and Cardiovasc. Surg.*, 59:461, 1970.

---

# Army Medicine wants more doctors who specialize.

If you're a physician specializing in pediatrics, anesthesiology, radiology, or internal medicine, we've got a full range of career opportunities for you.

These opportunities are available in a setting that's about as free from non-medical distractions as it's possible for a practice to be. If you're a doctor who's more interested in practicing medicine than the running of a practice, Army Medicine could be perfect for you. Just call your local Army Medical Counselor, and he will discuss specific assignment opportunities with you.

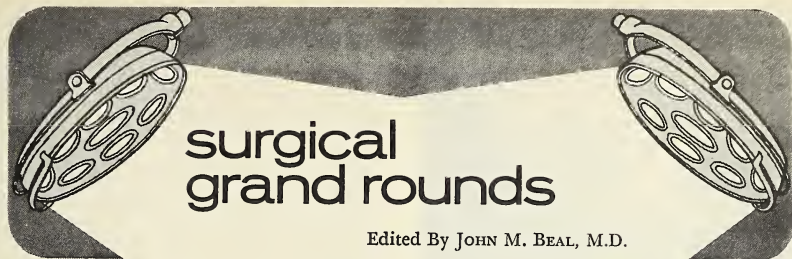
### Counselor/Phone Number

Captain Alex Fedorov 312-926-2147 or

Captain John G. Morris 314-268-3846

**Army Medicine. The practice that's practically all medicine.**

---



*Surgical Grand Rounds are held weekly on Tuesday at 5:00 p.m. in the Offield Auditorium of the Passavant Pavilion of Northwestern Memorial Hospital. Patient presentations from Northwestern Memorial Hospital and the Veterans Administration Lakeside Hospital form the basis of the discussions. This case report was part of the Surgical Grand Rounds of August 31, 1976.*

## CASE REPORT:

# Foreign Bodies in the Gastrointestinal Tract

**Dr. Robert Gordon:** A 38-year-old white male was admitted to Northwestern Memorial Hospital with a history of having swallowed six needles 10 days prior to admission. He complained of nausea, anorexia, and mid epigastric pain. The patient admitted having ingested needles and razor blades twelve times in the past and stated that he had been operated upon ten times for the same complaint. The most recent surgery had occurred eight months previously, when exploration was performed to remove needles.

Physical examination was essentially unremarkable except for the skin. The patient had multiple tattoos on his trunk and extremities. Abdominal examination revealed a midline scar. Laboratory studies included a hematocrit of 32%; white blood count, 15,000 and amylase, 99 units. The abdominal films were obtained.

**Dr. Helen Hull:** A film taken in December of

1975 demonstrated three metallic needles in the left upper quadrant of the abdomen, apparently in the stomach. On this admission, (Figure 1) there were six metallic needles of different sizes in the abdomen and several small metallic clips, which we will discuss later.

A lateral view also showed the multiple needles presumably in the gastrointestinal tract. There was no evidence of ileus obstruction, or free intraperitoneal air.

Chest film was normal. Postoperative films show that all the metallic needles have been removed and two metallic clips noted in the lower abdomen were felt to be surgical clips from previous operative procedures.

**Dr. Robert Gordon:** An attempt was made to gastroscopically remove the needles. Three needles could be seen in the stomach, but could not be removed with the use of forceps. Therefore, the patient was prepared



**Figure 1**

Plain film of abdomen at the time of admission revealed the presence of six needles.

for surgery. The patient was explored through the previous midline scar and multiple dense adhesions were encountered. An anterior gastrotomy was performed and two needles were removed from the pyloric area of the stomach. One needle was found in the fundus of the stomach. The fourth needle was located in the second portion of the duodenum and a fifth needle was found in the third portion of the duodenum immediately adjacent to the superior mesenteric vessels. All these needles were removed through the anterior gastrotomy. After a prolonged search, a needle was found which had perforated the proximal jejunum and was imbedded in the mesentery with a small adjacent abscess. The patient's postoperative course was uncomplicated.

## History

Interest in the subject of foreign body ingestion

dates to the Byzantine period, when a patient who had ingested a foreign object was advised to swallow a sponge. When the sponge was enlarged with fluid, the sponge was pulled out with the string and, hopefully, the foreign object. Another note from history stated that in Prussia, Frederick William I, father of Frederick II The Great, swallowed a belt buckle, which seems to be the first medical report of someone ingesting a foreign object. King Edward II died in office, apparently because his political associates did not approve of his multiple boyfriends. They placed a cow's horn into his rectum and through the cow's horn, inserted a heated iron rod. He died of peritonitis.

The first gastrotomy to remove a foreign body was performed in 1602. In 1735, an appendix which contained a pin was removed and in 1779, the first recorded presence of a foreign body in the small intestine was made. The first attempt to visualize the esophagus occurred in 1795, and in 1895, the first object was removed via bronchoscopy.

## Demographic Incidence

The most common age group for foreign body ingestion in infants, in the one to three year old category. Sixty percent of such patients are in this pediatric age group. Other common predisposing factors are dentures and high alcohol intake. Hasty eating or cool liquids are contributing activities. Cool liquids desensitize the mucosa of the mouth and therefore people may swallow objects without noticing them. Other contributing factors are poor vision and careless food preparation.

Another large category of people who ingest foreign objects includes psychiatric patients. These patients have an increased mortality because treatment is delayed as a result of unreliable or absent history of ingestion. A related group is exemplified by our patient, the manipulative swallower, who swallows objects repeatedly and then seeks medical care. Drug addiction is very common among people in this category. Foreign object ingestion is very commonly associated with schizophrenia. Some of these patients have markedly abnormal eating habits and may include foreign bodies with food.

The most common objects that are ingested include pennies and bones in the pediatric patients. Pull-top tabs have become a commonly swallowed object. Swallowing of the tab occurs after it has been dropped into the can of liquid.

In adults, meat and bones are the most common foreign objects. Papain maybe used to help dissolve meat. Trichobezoars (hair) and phytobezoars (fruits, seeds and vegetables matter) are often reported. Other foreign bodies, ingested chiefly by psychiatric patients, includes needles, razor blades and silverware.

Size and shape of the objects are very important in the treatment of these patients. Rounded objects rarely require operation, sharp pointed objects occasionally need operation, while long slender objects are the hardest for the gastrointestinal tract to pass. The time to pass foreign bodies through the alimentary tract varies and is shortest for round objects, approximately five days. If the object is pointed at one end, the transit time averages six days. If objects are pointed at both ends, they require approximately seven days. Sharp or pointed objects produce a reflex contraction of the muscularis mucosa and a decrease in peristalsis. However 90% of foreign bodies are passed without producing damage. Surprisingly, 70% of needles will pass. In one study dogs ingested hundreds of needles and none required surgery. Perforations of the intestine occur in less than 1% of patient who ingest foreign bodies.

### Lodgement in the Esophagus

Of all foreign objects, 80% are swallowed and 20% are inhaled into the respiratory tract. Esophageal foreign bodies most commonly lodge in the upper third (66%), 20% in the mid esophagus and 14% in the lower esophagus.

Briefly, esophageal foreign bodies usually lodge in the anatomical area of narrowing, just past the cricoid, at the level of the aortic arch just above the diaphragm or at the level of the left main stem bronchus. Most can be removed by esophagoscopy. A Foley® or Fogarty® catheter may be inserted past the object, the balloon expanded and the catheter retracted to remove the object. One should not attempt to avoid an esophagogram if the object is not radiopaque. One should use a cotton pledget whenever possible, soaked in radiopaque material in order to try to identify the object. An esophagogram with barium makes the esophagoscopy extremely difficult afterwards. Then, the patient should be observed for signs of mediastinitis, subcutaneous air, pain, or a rise in temperature. It is said that approximately 85% of objects which reach the stomach will pass the gastrointestinal tract with no problems. Esophageal ingestion of foreign bodies is suggested by chest or throat discomfort,

gagging, vomiting, sometimes increased salivation, trouble with swallowing or occasionally with airway obstruction. On physical examination one should inspect the pharynx with a mirror, check the neck for masses or subcutaneous air, and check the X-ray for mediastinal air or an air fluid level in the esophagus. Esophageal perforation is suggested by pain (substernal, neck, back, or epigastric pain), signs of systemic toxicity, a neck mass and subcutaneous emphysema. The treatment for esophageal perforation is exploration with removal of the foreign object, closure of the esophagus and drainage. At a later date, dilatation may be necessary.

### Rectal Foreign Bodies

The most common places of lodgement in the intestinal tract are at the pylorus and at the ileocecal valve, with 73% occurring at the latter. The rectum, sigmoid, and cardioesophageal junction are also places of lodgement.

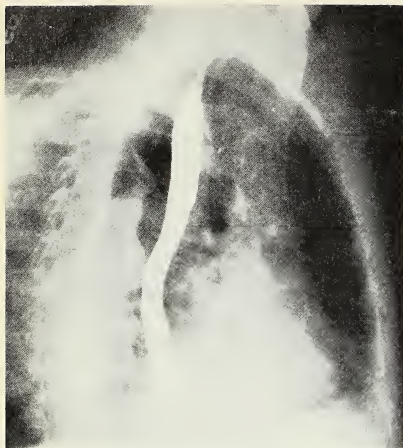
Rectal foreign bodies are common in homosexual patients. There are a variety of ways to remove rectal foreign bodies. A forceps may be used or a tube may be passed if the object is a bottle. The tube is passed into the bottle and plaster of Paris is allowed to harden and then the bottle is pulled out. The use of a Sengstaken tube has been described which is passed into the bottle, the balloon inflated and the bottle extracted. Operation is a last resort.

The conservative treatment of intestinal foreign bodies, recommended because 90% of foreign bodies will pass without incident, is a high residue diet, avoidance of cathartics and daily X-rays. The indications for surgical intervention are perforation, or obstruction. Hemorrhage is rare although this may occur in children who swallow Christmas bulbs. The fine glass lacerates the intestine and can cause serious acute hemorrhage.

Surgical intervention may be required after failure of movement of the foreign body. This may be caused occasionally by the presence of congenital anomalies (e.g. Meckel's diverticulum) or stenosis. Death resulting from ingestion of foreign bodies results chiefly from tracheal obstruction or perforation of intestine.

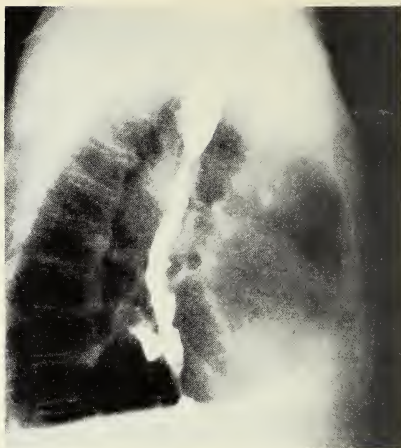
**Dr. Robert Vanecko:** Doctor Gordon has outlined some of the problems that occur with esophageal foreign bodies. Frequently, they are encountered in the extremes of age, the very young and the very old. People in certain occupations are prone to this misfortune. Common examples are carpenters and rug layers who keep





**Figure 2**

Esophagram at the time of admission shows irregularity in the distal esophagus in patient after ingestion of chicken bone.



**Figure 3**

Four days after ingestion of chicken bone, esophagram demonstrated obvious perforation of esophagus.

tacks or nails in their mouths while working. It is not unusual for them to swallow one of these objects. If these objects do not pass through the esophagus, they frequently lodge in the areas of normal narrowing, the cricopharynx, the mid portion of the esophagus, at the level of the tracheal bifurcation and arch of the aorta or at the cardioesophageal junction. The nature of the foreign body presents certain problems. Those that are radiopaque are easily seen on X-ray and it is easy to determine location and decide on a method of extraction. Other objects such as fish bones and plastics are more difficult to locate by X-ray and frequently require special cooperation from the radiologists. It may be necessary to have the patient swallow a barium impregnated pledget of cotton to determine at what level this object is lodged, or to hopefully tell if the object is not longer present in the esophagus. Removal may be a very simple matter; however the object itself or its removal can sometimes lead to a life threatening situation.

One problem occurs when the object is known to be in the esophagus and is visible on X-ray, yet at the time of esophagoscopy the object cannot be found. This is particularly true of needles that can be hidden in the folds of the esophagus.

The esophagoscope frequently will slide right by the object. It is sometimes necessary to obtain an X-ray with the esophagoscope in place in order to ascertain the object's location in relation to the scope. It is preferable to do the endoscopy under general anesthesia because it may take considerable time and possibly some maneuvering to extract the foreign body.

Meat boluses are frequently treated with papase which hopefully dissolves the fiber content and permits passage. At times a food bolus is very difficult to remove via the esophagoscope. After the bolus is located and one begins to pull on it, fragmentation occurs and removal of all the fragments is very difficult. Coins and straight pins, etc. are fairly easy to remove endoscopically if they can be located without difficulty.

### Special Problems

Objects with sharp edges, such as open safety pins, hair pins and tacks present special problems. Once they are located, the problem of how to remove them remains. Grasping the object, in the attempt to retrieve it, depending on its orientation in the esophagus, may perforate the esophagus and produce a more serious problem

than anticipated.

The solution may be a simple one. One can take the object in the line of direction that it is orientated, push it into the stomach, rotate it and then pull it back up the esophagus in such a way that the point will not tend to perforate. This looks very easy, but the people who have done esophagoscopies even without foreign bodies sometimes find it very difficult to visualize the cardioesophageal junction and to get the esophagoscope into the stomach. I would like to note another example of the multi-pointed object and, again, how the main principle in dealing with pointed objects is to manipulate them within the esophagus so that the dangerous pointed end can be neutralized as the object is withdrawn.

Another problem is delayed rupture. A gentleman swallowed a chicken bone. He had the signs and symptoms normally expected—substernal pain, difficulty in swallowing and excess salivation. A small line on the esophagram (Figure 2) is the only indication that the bone may be lodged in the esophagus. He did well for approximately four days; he then suddenly developed fever, tachypnea, and became obviously very sick. A repeat esophagram (Figure 3) showed that indeed something had occurred and

this fish bone had to be removed surgically as it had eroded through the esophagus causing mediastinitis.

**Dr. Stuart M. Poticha:** Unfortunately most non-psychotic patients who swallow foreign objects, fail to recognize the foreign body in their mouth. Often the foreign body is unnoticed until it causes a perforation. Patients do not feel foreign bodies in their mouths either because they are inebriated, or more commonly because the palate is covered by a denture. Most foreign bodies in the mouth are identified by feeling the object between the tongue and palate. One patient swallowed a toothpick, but the foreign body was unrecognized until the patient presented with an acute abdomen and exploration revealed a small bowel perforation. Every time I have been involved in one of these discussions, it becomes a contest between the attending surgeons as to who remembers the most bizarre swallowed object. Our candidate for the "can you top this" award is this young lady who had a congenital absence of sensation in her palate. While eating in a restaurant she felt something stick in her throat. In an attempt to remove the obstructing piece of food with an ice tea spoon she managed to swallow it. ◀

★  
*Specialized Service*  
IN  
**PROFESSIONAL LIABILITY INSURANCE**  
*is a high mark of distinction*  
**THE**  
**MEDICAL PROTECTIVE COMPANY**  
**FORT WAYNE, INDIANA**  
*Professional Protection Exclusively since 1899*

**CHICAGO AREA OFFICE:**

T. J. Pandak, J. C. Kunches, L. R. Gannon, and W. G. Prangle, Representatives  
814 Commerce Drive, Suite 101B, Oak Brook, Illinois 60521 (312) 325-7314

SPRINGFIELD OFFICE: W. J. Nattermann, Representative

426½ South Fifth Street, Springfield 62701 (217) 544-2251



## *Responsibility Before the Vote*

Several members recently contacted me to criticize actions taken by the House of Delegates at its recent meeting. The comments came from physicians who were, in effect, disenfranchised at that session.

These members had no voice in the policy-making process because their delegates were among those—from approximately one-third of the ISMS component societies—who did not attend! When a significant number of component societies are not represented, the effectiveness of the House is diluted.

Each component society must take steps to insure representation. A portion of the society's meeting prior to each House session should be devoted to business pending at the state level . . . and delegates should solicit the views of their constituents. Delegates representing larger societies should attend hospital staff, specialty society and other meetings to obtain the viewpoints of grass roots members. In addition, delegates should report—both formally and informally—after each House session.

It should be emphasized that responsibility for communication does not rest solely with the delegates. It is shared by each member. After-the-fact complaining does nothing to increase the strength of ISMS. Members must voice their opinions before action is taken . . . and insist that these views are presented during deliberations of the House of Delegates.

A handwritten signature in cursive script that reads "George T. Wilkins, Jr.".

George T. Wilkins, Jr., M.D.

# Doctor's News

**FIVE ILLINOIS PHYSICIANS** were nominated to serve on AMA Councils at the recent AMA Annual Meeting in San Francisco. **David S. Fox**, Chicago, ISMS President-Elect, was nominated for the Council on Constitution and Bylaws, **John J. Ring**, Mundelein, a member of the ISMS House of Delegates, was nominated for the Council on Medical Service, and **Sidney Levitsky**, Chicago, was proposed for the National Joint Practice Commission. **James R. DeBord**, Oak Park, a resident physician, was named for the Council on Scientific Affairs.

**PHARMACY PRACTICE ACT**—The Department of Registration and Education Bureau of Drug Compliance has announced a recent change in the rules for Administration of the Pharmacy Practice Act which is of particular interest to practicing physicians. Physicians are asked to note that the following sentence has been added to Rule X(1):

No prescription may be refilled for a period in excess of one (1) year from the date of the original filling of said prescription.

A complete listing of changes in the Administrative Rules may be obtained by writing the Bureau at 55 E. Jackson Boulevard, Chicago 60604 or the Department's Springfield offices at 628 E. Adams Street, 62786.

**CONTRIBUTIONS REQUESTED**—The AMA Board of Trustees recently approved a \$3,000 contribution toward a statue in honor of Doctor Thomas A. Dooley, whose work with the lepers in southeast Asia is an American legend. The statue will be placed in a national park in St. Louis, Missouri, the city where Doctor Dooley attended medical school. Physicians who wish to contribute to the project may write to: Mrs. Lucille Selsor, Chairman, The Dr. Tom Dooley Statue Committee, 1735 Delmar Boulevard, St. Louis, Missouri 63103.

**A NEW PERSPECTIVE**—the Illinois Council on Continuing Medical Education has announced that a new and particularly comprehensive booklet is now available to CME Planners. The subject, "Medical Audit, Continuing Medical Education and Quality Assurance" offers a fresh outlook on the challenge facing Illinois hospital staff. Paul J. Sanazaro, M.D., who authored the article, is a nationally respected scholar of both quality assurance and health care administration. ICCME urges that CME Committees inculcate the analysis as a provocative opportunity for self-learning and goal expansion. Copies may be obtained by writing Box J, Illinois Council on Continuing Medical Education, 55 E. Monroe Street, Suite 3510, Chicago 60603.

**APPROVED CANCER PROGRAMS ANNOUNCED**—The American College of Surgeons has released a listing of Illinois hospitals which have achieved approval in accordance with standards of the Cancer Program Manual. The 42 Illinois hospitals have been reviewed by on-site field surveyors reporting to the College. A complete listing of the programs, as well as information on the new Field Liaison Program of the ACS Commission on Cancer, may be obtained by writing to Andrew Mayer, M.D., F.A.C.S., Asst. Director, Professional Activities (Cancer), American College of Surgeons, 55 E. Erie Street, Chicago 60611. A variety of informational literature, including the ACS Cancer Program Manual, is also available from that office.



**AMA MEMBERSHIP REPORTED**—Despite a major dues increase, the American Medical Association has announced that 172,830 physicians, residents and medical students held dues-paying membership in 1976. Total AMA membership (including exempt and affiliate members) reached 203,584 in 1976. According to the AMA Center for Health Services Research and Development, the average age of all U.S. physicians is 46.3 years.

**PHYSICIANS IN THE NEWS**—Thomas E. Moran, M.D., was elected president of the Illinois Society of Pathologists at their annual meeting in April. Doctor Moran is director of the Christ Hospital blood bank in Oak Lawn. . . . The new chairman of the department of pediatrics for Loyola University's Stritch School of Medicine will be Lewis E. Gibson, Wilmette. . . . O. Howard Reichman, M.D., Elmhurst, was recently named chief of the division of neurological surgery at Loyola University's Foster G. McGaw Memorial Hospital.

Charles G. Stoll, M.D., Lawrenceville, was honored at a special dinner given by the Lawrence County Medical Society last month, noting his induction into the ISMS Fifty Year Club. ISMS Eighth District Trustee James Laidlaw, M.D., Champaign, presented the plaque and pin to Dr. Stoll, whose service to the community was praised by several speakers at the gathering.

Doctor Ruy V. Lourenco, Glencoe, has been appointed to head the Department of Medicine at the University of Illinois Abraham Lincoln School of Medicine. Doctor Lourenco, a native of Portugal, has served as director of the Section of Pulmonary Diseases at the Medical Center. . . . Also at the Medical Center, Alan Donaldson, M.D., LaGrange, has been asked to serve as acting dean for the Chicago Medical Center's School of Public Health. Doctor Donaldson, a Ph.D. in international health, has been an associate dean in the School of Public Health for the past six years.

The Loyola University Medical Center has announced that John R. Tobin, Jr., M.D., M.S., received the John W. Clarke Professor of Medicine award at Loyola University's Stritch School of Medicine. The award cited Dr. Tobin's performance as chairman of the department of medicine, and a "dedicated teacher and a superb physician." Dr. Tobin, a co-editor of the *IMJ EKG of the Month* series, has also been associated with Cook County Hospital in Chicago and the Mayo Clinic in Rochester, Minnesota. John Ellsworth Affeldt, M.D., has been appointed director of the Joint Commission on Accreditation of Hospitals.

Isadore M. Isoe, M.D., Chicago, was recently lauded with a special resolution from the Illinois State Senate in appreciation of his "nearly three decades of excellent service." Doctor Isoe serves the medical staff of Norwegian-American Hospital in the post of chairman for the department of surgery.

The American College of Physicians admitted 23 Illinois doctors as Fellows at their April meeting. Illinois physicians receiving the accolade include: Parkash D. Gupta, Berwyn, Arcot J. Chandrasekhar, Clarendon Hills, Henry N. Coleman III, Evergreen Park, Iltifat A. Alavi, LaGrange and Larry S. Milner, Northbrook. Chicago physicians admitted were Alan R. Aronson, Jose A. L. Arruda, David S. S. Chan, Alan A. Harris, Henry B. Head, Bann Kang, Paul E. Kaplan, Antonio Quintanilla-Paulet, Arthur H. Rosssof and Jayendra H. Shah. Doctors Robert W. Hedger and Joseph H. Oyama of Oak Park, Arthur M. Morris, River Forest, Frank Chmelik, Rockford, Phillip M. Berman, Skokie, Frederick G. Berlinger and Robert M. Craig, Wilmette and Edward D. Murphy, Winnetka, complete the list of new Fellows.

# 1977 Convention Summary



New Officers and Trustees . . .

Highlights of Convention '77 . . .

Summary of House Actions

# Illinois State Medical Society

## 1977-78 Officers and Board of Trustees

### Officers

PRESIDENT  
PRESIDENT-ELECT  
1st VICE PRES.  
2nd VICE PRES.  
SEC.-TREAS.  
CHAIRMAN, BOARD  
OF TRUSTEES

George T. Wilkins, 3165 Myrtle, Granite City 62040  
David S. Fox, 826 E. 61st St., Chicago 60637  
Theodore Grevas, 2701 17th St., Rock Island 61201  
William M. Lees, 6518 N. Nokomis, Lincolnwood 60046  
Eugene P. Johnson, P.O. Box 68, Casey 62420  
Robert T. Fox, 2136 Robincrest Lane, Glenview 60025

### House of Delegates

SPEAKER  
VICE-SPEAKER

Cyril C. Wiggishoff, 25 E. Washington, Chicago 60602  
Robert P. Johnson, 108 Maple Grove, Springfield 62707

### Trustees

1st District	1980	John J. Ring, 401 Hillsdale, Mundelein 60060
2nd District	1980	Allan L. Goslin, 712 N. Bloomington, Streator 61364
3rd District	1980	Herschel Browns, 4600 N. Ravenswood, Chicago 60640
	1979	Alfred Clementi, 675 W. Central Rd., Arlington Heights 60005
	1980	Audley F. Connor, Jr., 3233 S. King Dr., Chicago 60616
	1980	Alfred Faber, 3851 N. Mission Hills Road, Apt. 401, Northbrook 60062
	1979	Robert T. Fox, 2136 Robincrest Lane, Glenview 60025
	1978	Henrietta Herbolsheimer, 5528 S. Hyde Park Blvd., Apt. 1202, Chicago 60637
	1978	Lawrence L. Hirsch, 2434 Grace, Chicago 60618
	1978	Eugene T. Hoban, 6429 North Avenue, Oak Park 60302
	1980	Joseph Sherrick, 303 E. Superior, Chicago 60611
	1979	Herman Wing, 155 N. Harbor Dr., Chicago 60601
4th District	1979	Fred Z. White, 723 N. 2nd St., Chillicothe 61523
5th District	1979	Paul F. Mahon, Dept. Radiology, St. John's Hospital, Springfield 62701
6th District	1978	Robert R. Hartman, 1515A W. Walnut, Jacksonville 62650
7th District	1979	Alfred J. Kiessel, 1 Powers Lane Pl., Decatur 62522
8th District	1979	James Laidlaw, 104 W. Clark, Champaign 61820
9th District	1978	Warren D. Tuttle, 203 N. Vine, Harrisburg 62946
10th District	1978	Julian W. Buser, 6600 W. Main, Belleville 62223
11th District	1980	Kenneth A. Hurst, 52 Bunting Lane, Naperville 60540
12th District	1980	P. John Seward, 2400 N. Rockton, Rockford 61101

### Trustee-at- Large

1978 Joseph H. Skom, 707 Fairbanks Court, Chicago 60611

# Highlights of the ISMS Annual Meeting

## April 24-27, 1977

A total of 585 physicians, medical students, guests and staff members attended the 137th annual meeting of the Illinois State Medical Society at the Holiday Inn-Mart Plaza, Chicago, April 24-27, 1977. In addition to their work in the House of Delegates and reference committees, attendees participated in clinical and issue oriented meetings sponsored by ISMS and affiliated specialty groups.

Attendance reported by the Credentials Committee for the 1977 House of Delegates is shown below:

	First Session	Second Session	Third Session
Officers and Trustees	28	24	21
Speaker and Vice-Speaker	2	2	2
Downstate Delegates	76	78	79
CMS Delegates	110	108	111
Intern/Resident	1	1	1
Student		1	1
Total	217	214	215
	(46 counties)	(55 counties)	(50 counties)

The first session of the House of Delegates was convened by James A. McDonald, M.D., Speaker of the House, at 2:30 p.m., Sunday, April 24. Jacob E. Reisch, M.D., ISMS Secretary-Treasurer, conducted a brief memorial service for 159 ISMS members who had died in the past year.

### ISMS Auxiliary Reports Progress

Mrs. Jane Ovitz, ISMS Auxiliary President, was introduced to the First Session of the House by P. John Seward, M.D., District 12 Trustee, who complimented her wide accomplishments and the progress made under her able leadership.

The Illinois State Medical Society Auxiliary received a special award at the AMA Auxiliary convention in Dallas for the largest total (medical society and auxiliary combined) dollar contribution to AMA-ERF. In addition, Mrs. Ovitz told the House, the Auxiliary received a membership award for establishment of the McDonough County Auxiliary.

Mrs. Ovitz noted that legislative and political participation had played a significant role in



Mrs. Ovitz addresses the opening session of the House of Delegates.

Auxiliary programming this year. Individual counties had held legislative programs and some actively endorsed friends of medicine through newspaper advertisements.

Two projects of particular importance have been completed this year. The Auxiliary now has a

501 (c)-6 status for income tax purposes and will be filing Articles of Incorporation with the State of Illinois as a not-for-profit organization.

The Auxiliary "Guidebook," which gives instructions and job descriptions for Auxiliary officers, has been revised, and the new edition prepared for the annual meeting.

Expressing special thanks to ISMS, Mrs. Ovitz lauded constant support on both moral and financial levels, as well as the efficiency with which cooperation has been extended.

"The Past is Prologue," has been this year's ISMSA motto, and Mrs. Ovitz offered that the annual meeting would provide yet another opportunity for sharing ideas and laying groundwork for the coming year. In conclusion, Mrs. Ovitz invited physicians to join in the "Golden Jubilee" celebration of the fiftieth anniversary of the Auxiliary founding.

### AAMA: Membership and Educational Advancements

Eli Borkon, M.D., AAMA liaison, introduced Mrs. Ruby Jackson, CMA, President of the Illinois Society, American Association of Medical Assistants. Education is the primary goal of AAMA, Mrs. Jackson said, as she recounted strides made by the society over the past year. Projects ranging from clinical symposia to government workshops have spotlighted constant work toward professionalism in the role of medi-



cal assistanceship.

ISMS Government Workshops were held in four sites across the state, and hosted guests from Medicare, Medicaid, Medichex and Champus. Six travel courses were held in Illinois this year.



Mrs. Ruby Jackson, President, AAMA, Illinois Society.

Mrs. Jackson said, and a personal development seminar, "Financial Management for Women," will be held in Decatur. Illinois Society, AAMA, also hosts an annual program at the Midwest

Clinical Conference under the aegis of the Chicago Medical Society.

Mrs. Jackson also announced that the Illinois Society annual meeting would be held in Kankakee on April 28, and center on the theme, "Grow with Knowledge and Friendship."

The AAMA president noted with pleasure that several projects had facilitated acquaintance with ISMS members across the state whose kindness and courtesy were most appreciated. "We are most grateful for all you have done for us," she concluded, "and look forward to the future, to accomplish to the fullest the purposes which have brought us together."

### Continuing Medical Education Awards

Doctor Robert T. Fox, Chairman of the Board of Trustees, presented 22 certificates of accreditation to Illinois organizations and institutions which have achieved recognition under the AMA guidelines for continuing medical education. The recipients of accreditation certificates, Dr. Fox said, offer Category I CME credit for participants renewing Illinois licenses under the new Illinois Continuing Medical Education law, and also can be applied toward the AMA Physician's Recognition Award. The following received accreditation certificates at the 1977 annual meeting:

Copley Memorial Hospital  
Swedish Covenant Hospital  
MacNeal Memorial Hospital  
Illinois Masonic Medical Center  
Illinois Heart Association  
Alexian Brothers Medical Center  
Riveredge Hospital  
St. Francis Hosp. and Medical Center  
(Peoria)  
Swedish-American Hospital

Mt. Sinai Hospital Medical Center  
Elgin Mental Health Center  
Southern Illinois Medical Assn.  
Tinley Park Mental Health Center  
Christ Community Hospital  
Ill. Soc. Ophthalmology & Otolaryngology  
Allergy & Clinical Immunology Society  
of Illinois  
Garfield Park Community Hospital  
Augustana Hospital  
Holy Cross Hospital  
South Chicago Community Hospital  
Rock Island Franciscan Medical Center  
Northwest Community Hospital

Dr. Fox also extended certificates of appreciation to Illinois Accreditation Examiners, who visit applicants for accreditation and assess their status. The chairman made special note of the time and effort extended by examiners in advancement of continuing medical education, and the training that enables them to describe, evaluate and determine Category I status. These individuals received certificates:

Joseph Skom, M.D.  
Morgan Meyer, M.D.  
L. Penfield Faber, M.D.  
William M. Lees, M.D.  
Thomas Zimmerman, Ph.D.  
Chase Kimball, M.D.  
Eugene Scherba, M.D.  
Jacob R. Suker, M.D.  
A. E. Livingston, M.D.  
Bradford Claxton, M.Ed.  
Lawrence Hirsch, M.D.  
Cyril C. Wiggishoff, M.D.  
Ward E. Perrin, D.O.  
Mather Pfeiffenberger, M.D.  
Joel Brumlik, M.D.  
John M. Holland, M.D.  
Fred Z. White, M.D.  
Sheldon S. Waldstein, M.D.  
Norbert Nadler, M.D.  
George Shropshear, M.D.  
Eugene T. Hoban, M.D.  
Henri Havalda, M.D.  
John G. Demakis, M.D.  
Joseph O'Donnell, M.D.  
J. Ernest Breed, M.D.  
Frank Jirka, M.D.  
Charles Weigel, M.D.  
Donald Pochyly, M.D.  
Joseph Bordenave, M.D.  
Paul Sunderland, M.D.

## AMA-ERF Check Presented

Dr. Joseph Skom, ISMS President, introduced J. A. Wells, M.D., Ph.D., Dean of the Loyola University Stritch School of Medicine, representing the Illinois Council of Medical School Deans, and presented a check for \$136,138.86 from the



Doctor Skom and Mrs. Jane Ouitz, ISMS Auxiliary President, present AMA/ERF check to J. A. Wells, M.D.

American Medical Association Education and Research Foundation. Dr. Skom announced that total 1977 contributions to AMA-ERF amounted to \$1,180,000 nationally. The funds will be distributed among Illinois medical schools as follows:

Rush Medical College, Chicago	\$11,658.49
University of Chicago, Pritzker School of Medicine	\$13,537.70
Northwestern University Medical School of Chicago	\$29,639.99
University of Illinois Foundation	\$14,110.73
Chicago Medical School	\$16,653.20
Stritch School of Medicine, Loyola University	\$20,940.83
Southern Illinois University School of Medicine	
Foundation, Springfield	\$ 6,776.97
Southern Illinois University Foundation, Carbondale	\$ 290.00
University of Illinois Foundation, Abraham Lincoln Campus	\$13,372.56
University of Illinois Foundation, Champaign	\$ 1,902.42
University of Illinois Foundation, Metro Campus	\$ 1,402.42
University of Illinois, Rockford School of Medicine Foundation	\$ 3,725.67
University of Illinois, Peoria School of Medicine Foundation	\$ 8,904.95
	<hr/>
	\$136,138.86

## IMPAC Credits Membership Activity

Mrs. Pam Taylor, chairman of the Illinois Medical Political Action Committee, rose to express her gratitude to ISMS members, and most particularly to the thirty-member IMPAC Council and officers. Friends of medicine found an overall 1976 election victory of 92% and membership has risen dramatically. IMPAC membership now stands at 9,547, Mrs. Taylor said, which is an all time high. In addition, Illinois leads the nation in total woman members.



IMPAC Chairman Pam Taylor reports to the House.

But membership and past victories are not enough, Mrs. Taylor stressed. Adding that this all time high in membership constitutes only 46% of total ISMS membership, she urged active participation in the political process. "Votes cast in elections," she concluded, "not letters after elections, have the greatest impact on members of Congress."

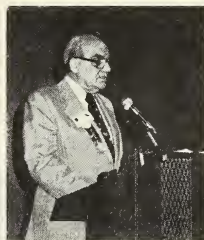
## Report of the Executive Administrator

ISMS Executive Administrator Roger N. White recalled intensified endeavors in the medico-legal and political arenas, and predicted that ISMS legislative activities would become increasingly productive and worthwhile under the new state administration.

Mr. White reported that the 1976 fiscal year closed with a small surplus, and that a balanced

budget could be expected in 1977. Funds are short, however, because 1977 marks the last year of a five-year dues increase, and contingency amounts have already been exhausted.

He then introduced Mr. Joel Edelman, who will serve as part-time corporate counsel for ISMS, ISMIS and IFMC. Although other legal counsel



Executive Administrator Roger N. White summarizes ISMS activities.

will be retained on a fee-for-service basis, it is anticipated that Mr. Edelman, who brings his experience as a former hospital administrator

and state welfare director, will expedite much of the research sent outside and enable ISMS to "contain an otherwise skyrocketing bill for legal services." (Defense of a chiropractic antitrust suit, in which ISMS has been named co-defendant with several other medical organizations, has already cost the society \$20,000, he noted.)

Mr. White also thanked the officers, trustees, ISMS members and staff for their cooperation over the past year. "The officers and Board of Trustees have done a yeoman's job," he said. "They have been called upon repeatedly by staff for heavy commitments of their time. Their response is most gratifying. The same can be said of many of the society's council and committee members. On behalf of the staff, I should like to express our deepest appreciation."

### **Report of the Chairman of the Board of Trustees**

Doctor Robert T. Fox, Chairman of the ISMS Board of Trustees, reported that the Board has acted on every action referred to it during the 1976 Interim Session of the House of Delegates. He indicated frustration in dealing with some state agencies but also noted that the new administration had shown interest in communicating with ISMS.

Dr. Fox traced difficulties encountered by the Illinois Foundation for Medical Care in carrying out the 1975 Interim Session directive to serve as ISMS negotiating arm with IDPA and third party payors for reconciliation of Medicaid administration and reimbursement disagreements. He described the alternatives IFMC had proposed to IDPA—including ombudsman programs, automated billing systems, and prior-to-payment agreements. Because the Illinois Department of Public Aid refused to acknowledge IFMC as representative of Illinois physicians, some activities were assumed by the Board and Committee on Health Care Reimbursement. "If we're to successfully negotiate with the state government,"

Dr. Fox said, "the Society itself must do the negotiating."

Dr. Fox' written report covered a wide range of activities by the Board of Trustees over the past twelve months, and particularly those since the Interim Session. ISMS policy on national health insurance, which the House of Delegates had mandated in November, was found to contradict ISMS standing as an AMA membership organization bound to abide by AMA policy. In addition, the chairman's report stated, the Board has strongly opposed "death with dignity" legislation and determined that the "Captain of the Ship Doctrine" in emergency rooms, which was debated at the Interim Session, is not an appropriate area for legislation at this time.

The report concluded with a note on the ISMS Leadership Conference in March. The conference hosted 110 physicians and executives from throughout the state, and focused on Medicaid, malpractice, legislation, medical discipline and rising health costs.

### **Illinois Delegation to the American Medical Association**

Jack L. Gibbs, M.D., chairman of the Illinois Delegation to the American Medical Association, introduced the members of the ISMS AMA Delegation. In his written report to the House, Dr. Gibbs stated that the ISMS delegation to the AMA had submitted a total of 18 resolutions to the AMA House of Delegates in 1976. The issues ranged from re-evaluation of PSRO's to methods



*Doctor Robert Fox, Chairman of the ISMS Board of Trustees, delineates areas of concentrated activity.*



*1977 ISMS Delegates to the American Medical Association.*



to improve legislative liaison mechanisms.

The 1978 AMA delegation was elected at the close of the final House session. The following physicians were elected: Howard C. Burkhead, Herschel L. Browns, Theodore Grevas, Morgan Meyer and Fred A. Tworoger, who were elected to an additional term as delegates. Dr. Joseph Skom will replace Dr. Edward A. Piszczek, whose term expires in December, and Jack L. Gibbs, M.D., will continue to serve as chairman.

Robert R. Hartman, Eugene P. Johnson, Glen E. Tomlinson and George T. Wilkins will continue to serve as alternate delegates in 1978. Doctors J. M. Ingalls, George Shropshire and Joseph B. Moles will be replaced by Doctors Lee Johnson, Maynard I. Shapiro, Audley F. Connors, Andrew Thompson and Cyril C. Wiggishoff, beginning in January.

### **President's Valedictory**

In his address to the House, Joseph H. Skom, M.D., ISMS President, said he had found the learning experience over the past year to be "expedient," and looked forward to a positive state administration where genuine communication and "free and friendly intelligent appraisal of our proposals" could be expected.

Dr. Skom pointed out that although some honest differences of opinion had arisen during his term, "this merely underscores the fact that ours is a truly democratic medical society."

Along with his usual humorous anecdotes, Dr. Skom discussed his feelings about the year. "In my inaugural address," he said, "I stated that if I ever found myself in a position of having to defend a policy that went against my conscience, I would resign. I am happy—but not surprised—that this situation never even threatened to develop."

Doctor Skom added that he had particularly enjoyed the "Presidents Tour" as an opportunity to meet grass roots membership. He thanked the officers, Board members and House of Delegates for their cooperation and support, and, in closing, told the House: "It has been a privilege and honor to serve as your President."

### **Reference Committees Convened**

On Sunday evening, April 24, the reference committees met to consider resolutions. Between 7:30 p.m. and 1:00 p.m. the following day, the committees debated and formalized recommendations on the resolutions presented to the House. The debates, which are open forums for all

members to express opinions, continued past midnight in some committees. They then met in executive session and remained sequestered until final reports were completed.

The Reference Committee on Amendments to Constitution and Bylaws, chaired by John Hyde, M.D., considered resolutions ranging from the participation of student and resident members of ISMS to proposed restructuring of several ISMS councils and committees.

Reference Committee A considered resolutions related to officers, administration, finances and budgets. The committee, chaired by Burton Soboroff, M.D., debated numerous other issues, including redistricting and a proposed political code of ethics.

Reference Committee B was chaired by Harold J. Lasky, M.D., and concerned itself with government health programs, most often problems with the Illinois Department of Public Aid. Discussion considered current audit procedures and efforts to investigate and curb alleged abuses of the Medicaid system.

Education, manpower and clinical medicine resolutions were assigned to Reference Committee C. Chairman F. H. Riordan, M.D., guided discussion on such issues as continuing medical education funding and expansion.

In Reference Committee D, chaired by Charles A. DeKovessey, M.D., social and medical services, environmental and community health and all economic matters outside of government programs were discussed. Questions of peer review and the use of the term "physician," as well as generic labeling for drugs crossing international borders were among the questions confronted.

Reference Committee E, to which governmental affairs and medical-legal issues were assigned, was chaired by Dr. Robert Hamilton. The committee heard testimony from several "permit physicians" with regard to the recent DMHDD crisis, discussed a modified anti-substitution law, "death with dignity" legislation, and a number of other issues.

National Health Insurance was among the more heated subjects in Reference Committee F, which dealt with public relations, membership services and miscellaneous business. Chairman Loren Boon, M.D., also coordinated discussion on the definition of an expert medical witness and unified membership with the American Medical Association.

Doctor Robert A. Behmer served as chairman for Reference Committee G, where most of the discussion centered on the future of the Illinois Foundation for Medical Care.





*ISMS past presidents. Standing, (l-r) Drs. J. Ernest Breed, Newton DuPuy, Edward Piszczek, Host Jacob E. Reisch, C. J. Jannings, III, Burtis Montgomery, H. Close Hesselstine, and Willard C. Scribner. Seated from left are Drs. Caesar Portes, Leo P. A. Sweeney, E. P. Coleman, Fredric Lake, J. M. Ingalls, immediate past president, and Frank J. Jirka, Jr.*

### Past President's Dinner

Saturday evening, April 23, 14 past presidents gathered for a gourmet dinner at the Chicago Ritz Carlton Hotel. Dr. Jacob E. Reisch served as master of ceremonies, as the past presidents honored J. M. Ingalls, immediate past president.

### Alcoholism Workshop

The ISMS Committee on Emergency and Disaster Care, in conjunction with the Chicago Hospital Council, sponsored a day-long forum on "The Alcoholic in the Emergency Room." Max Klinghoffer, M.D., member and former chairman of the Committee, served as moderator for the program.

Workshop speakers included representatives from the Department of Mental Health and Developmental Disabilities, the Illinois Department of Public Health, law enforcement personnel, and members of the social service and medical community.

Discussion at the workshop revolved around pragmatic areas of concern, particularly those brought out by the new Alcoholism Treatment Licensing Act. Treatment methods in non-hospital settings were discussed, in conjunction with an overview of the unique complications of treating alcoholic patients. Efforts toward coordinating services and referral links among involved agencies, ranging from law enforcement to hospital personnel, provided an underlying focus for the interchange.

### Continuing Medical Education Highlights

The Illinois Council on Continuing Medical Education sponsored a number of programs at

the annual meeting. The annual meeting of CME accreditation examiners included an amusing—and educational—mock CME site visit to a mythical Illinois hospital seeking accreditation. The examiners were given the full plethora of updated forms and requirements, and a mock board of directors was placed under the spotlight for cross-examination.

ICCME also held three workshops. On Monday, those seeking accreditation were invited to attend a forum, and a second workshop was held on CME planning in accredited institutions. Tuesday's workshop on CME leadership was also well attended.

### IMPAC Workshop

The Illinois Medical Political Action Committee sponsored a day-long workshop in conjunction with its annual meeting on Monday, April 25. Rex Kenyon, M.D., chairman of the

American Medical Political Action Committee Board (AMPAC) addressed "The Road Ahead for Medical Politics, 1977-1978." Doctor Kenyon noted that IMPAC held second place in total dollar contributions to AMPAC nationally, and third place in the competition for largest increase ov-



*Congressman Edward J. Madigan addresses the IMPAC Workshop, on "Practical Politics, The How and Why."*

er the prior year's donation.

"The important thing to recognize in politics is the difference between things which can be changed and those that can't," Douglas I. Bailey, president of Bailey, Deardourff and Associates, told the gathering. Bailey's presentation, "The Media Conscious Physician" included a visual demonstration with film clips of various techniques for electronic media campaigns.

George T. Wilkins, M.D., ISMS President-Elect and AMPAC Board member, gave a brief summary of current legal and political activity.



ISMS President-Elect Doctor George T. Wilkins at the IMPAC Workshop.

Congressman Edward J. Madigan told the attendants about "Candidate Support—The Candidate's View." Some supporters, he said, had voted for him on their doctors' word alone. "My doctor likes him," they had told him, "and that's good enough for me."

Madigan said that personal contact remained the strongest political arm of organized medicine. In closing, he urged, "talk to your patients."

### Fifty Year Club Luncheon

The annual luncheon honoring members of the ISMS Fifty Year Club convened Monday to induct 81 new members to their distinguished group.

H. Close Hesselstine, M.D., ISMS Past President, was keynote speaker for the luncheon. Doctor Hesselstine capsulized the advances in medicine in their generation, telling anecdotes about

early practice, when surgery was prohibited for older persons, family planning unheard of, and vaccines unknown. "Ours is a glorious time in medicine," Dr. Hesselstine told the group. "At no other period have such advances been made. Ideas, skills, competence, enthusiasm and just plain good observation," Dr. Hesselstine said, had been responsible.

David S. Fox, M.D., presented plaques to the new Fifty Year Club members, and also spoke briefly in commendation of the 734 member society. Special pins were awarded to the 10 doctors joining the Sixty Year Club, made up of those who had begun their practice in 1917.

### Public Affairs Breakfast

The ISMS Public Affairs Committee hosted a special breakfast on Tuesday morning with Honorable Alan J. Dixon, Illinois Secretary of State, as guest speaker. Dixon related a number of amusing stories and also noted several recent innovations to serve the needs of medical professionals. The new drivers licenses will include two new stickers—one to designate organ donors and a second for persons with special medical information crucial to emergency room personnel.

Also at the breakfast, Rex Kenyon, M.D., Chairman of the AMPAC Board, presented an award to Mrs. Jane Ovitiz, President of the ISMS Auxiliary. In accepting the



Rex Kenyon, M.D., AMPAC Board Chairman, presents membership award to Mrs. June Ovitiz, ISMS Auxiliary President.



Some new members of the ISMS Fifty Year Club with Dr. David S. Fox, host.

award for his best woman AMPAC membership in 1976, Mrs. Ovitz urged the group to be please—but not satisfied, and to intensify their efforts toward full participation.

### Clinical Symposia

The Illinois Society for Physical Medicine and Rehabilitation presented a forum on "Evaluation and Treatment of Learning Disabilities" at the annual meeting. The Illinois Society of Pathologists' program, "Surgical Pathology Problems Cases" conducted by Paul B. Szanto, M.D., director of pathology at the Hektoen Institute for Medical Research of Cook County Hospital and members of the Illinois Tumor Registry, was also well attended.

### Some Special Resolutions

Jacob E. Reisch, M.D., was honored on the floor of the House by unanimous vote as a committee of the whole

with a special resolution making him Secretary-Treasurer Emeritus. Doctor Robert Hartman was similarly lauded for his outstanding work as chairman of the Governmental Health Program Reimbursement Committee. Doctor James MacDonald, concluding his term as Speaker of the House, was commended for his "remarkably good humored, efficient utilization of the limited time of the House, and his respect for the opinions of all."

Also singled out for special notes of appreciation were Dr. Fredric Lake, ISMS President Dr. Joseph Skom and ISMS Executive Administrator, Roger N. White.

### President's Dinner

The annual ISMS President's Night, honoring President Joseph Skom, M.D., was attended by over 300 physicians, auxiliaries and special guests. Doctor Fred Z. White served as master of ceremonies for the program, which included entertainment by the Second City, a Chicago theatre group, and music by the Alan Kaye Orchestra.



*Jacob E. Reisch, M.D., ISMS Secretary-Treasurer, presents special award to Dr. Fredric Lake for his work with the Task Force on Professional Liability.*

### Doctor Wilkins Inducted

Doctor Joseph Skom installed George T. Wilkins, M.D., as 1977 President of ISMS at the closing session of the House. Dr. Wilkins called upon Dr. Mack W. Hollowell, chairman of the Council on Public Relations and Membership Services, to present the traditional outgoing president's scrapbook. The scrapbook contains newspaper clippings from the past year featuring the president's activities.

In his inaugural address, Doctor Wilkins said that the health care system stands as the last great frontier for social change, and urged physicians to intensify their efforts in the interest of the medical community. "Take a firm stand and look reality straight in the eye instead of day-dreaming of the way we'd like it to be," he urged.

Stating that "society has concluded that health care is a right based on the single criterion of need," Doctor Wilkins called for a "basic philosophy allowing for more rational decisions." Cost containment, he said, will continue to be the catalyst for the transformation of American medicine and represents a collective challenge for the medical profession. "Critics promote distortions," he said. "High quality care is high cost care." Abstract components such as inflation, increased demands on technology, needs of the elderly and the Medicaid system were cited as elements affecting the cost crisis.

Doctor Wilkins urged physicians to work in the political system at all levels. "If we disagree, we must formulate and develop a viable alternative," he said. "Vote for and support your candidates. Public relations will never help," he concluded, "if we don't talk to our patients."



*Doctor Reisch presents commemorative gavel to Dr. James A. McDonald, retiring Speaker of the House of Delegates.*



# Summary of Actions of the House of Delegates

## REFERENCE COMMITTEE ON AMENDMENTS TO CONSTITUTION & BYLAWS

1. Approved for consideration of the 1978 annual meeting of the House of Delegates amendments that would: (A) Allow the ISMS Constitution to be amended at either an annual or interim session of the House—provided the amendment has been proposed at a preceding annual or interim session; and (B) Eliminate any constitutional reference to a specific number of trustees, calling only for such trustees and other officers as the Bylaws may provide.
2. Approved amendments to clarify dues delinquency dates in Bylaws Chapters I, II and X to provide that: (A) Any county society which fails to transmit to ISMS dues collected from its members prior to March 31 shall be held as suspended and none of its members permitted to participate in the proceedings of the society; and (B) Members whose dues remain unpaid by April 30 will be dropped automatically from membership.
3. Amended Bylaws Chapter I, Section 1C to require applications for emeritus status be received by component societies prior to December 31 in order to be effective the following year. This section was editorially changed to clarify that applicants must have been members of the Society for 35 years in addition to being 70 years old to qualify for emeritus status.
4. Amended Bylaws Chapter IV to: (A) Describe the Resident Physicians Section and Student Business Session and provide for each to name one voting delegate and one alternate delegate to the ISMS House of

Delegates; (B) Provide in the House of Delegates the privilege of the floor without vote to one representative from each member organization of the Council on Affiliate Societies; (C) Extend to the interim session the same resolution deadlines that have been in effect for the annual meeting; and (D) Exempt the Resident Physicians Section and Student Business Session from these deadlines by allowing each organization to present resolutions for consideration by the House of Delegates at any time before the close of business of the first day session of the House.

5. Amended Bylaws Chapter IX to merge the Council on Environmental and Community Health and the Council on Social and Medical Services into a single council to be known as the Council on Medical Service.
6. Referred to the Board of Trustees for implementation as a Bylaw amendment the definition of "immoral and gross misconduct" as being: (A) Adjudged guilty by civil authorities of a criminal offense involving moral turpitude; or (B) Adjudged guilty by his county society of repeated acts of serious misconduct as a physician or violating the ISMS or component society bylaws or AMA Principles of Medical Ethics.

## REFERENCE COMMITTEE A

1. Directed the Planning and Priorities Committee to study means by which the Society can become a stronger advocate of its members in professional, social and economic problems and to report its recommendations to the House of Delegates at the 1978



annual meeting.

2. Instructed the Board of Trustees to seek adequate office space in Springfield for legislative, public affairs, continuing medical education, negotiations and insurance activities on a continuing basis—as well as providing adequate space for fairly large committee meetings—and present a progress report on this endeavor to the House of Delegates at its 1977 interim session.
3. Referred to the Board of Trustees for study and report back to the House of Delegates at its 1977 interim session a resolution that would establish procedures to remove from office any ISMS officer, trustee, or delegate who makes a public statement contrary to the basic philosophy and policy of the Society.
4. Rejected proposals to:
  - (A) Study the feasibility of building or purchasing office facilities for ISMS. Because the present lease on Chicago office space has eight years to run, the time for building or buying property was not considered to be propitious.
  - (B) Change the method of selecting reference committee members to avoid any conflict of interest and form an ad hoc committee to develop a political code of ethics to be completed by all elected officers of ISMS and component societies. The need for such action was not demonstrated.
  - (C) Require the Redistricting Committee to conduct annual surveys to determine attitudes about existing districting and to analyze growth trends so that districting changes can be made to provide more equal numerical representation. Much of this activity is already being done by the Redistricting Committee.

## REFERENCE COMMITTEE B

1. Agreed to request AMA to seek immediate discussions with Congress and HEW to eliminate as an inequitable form of payment the use of outdated fee profiles under Medicare Part B.
2. Commended Dr. Robert Hartman for his outstanding job as Chairman of the Governmental Health Program Reimbursement Committee.
3. Agreed to request IDPA to reimburse phy-

sicians for providing consulting services to Medicaid patients.

4. Directed ISMS leadership to move administratively to seek immediate correction of the outrageously low IDPA fees.
5. Agreed to investigate IDPA policies on dispensed items and ascertain why the state does not properly reimburse physicians for injectable drugs supplied and administered, and ensure, using whatever means necessary, that IDPA properly and promptly pays for injectable drugs.
6. Directed the Board of Trustees to investigate IDPA policies on laboratory culture and sensitivities for Medicaid patients and ascertain why the Department does not reimburse Illinois physicians for obtaining culture and sensitivities from appropriate laboratories which provide results within three days.
7. Agreed to request the Legislative Advisory Committee to IDPA to encourage investment in high quality, comprehensive facilities if it believes that formation of a network of facilities will increase access to health care for the poor.
8. Directed ISMS leaders to take an active role in helping IDPA and the Legislative Advisory Committee reach a decision regarding administration of Medicaid by a private firm and that those ISMS participants be, in part, expert, knowledgeable, interested physicians experienced in the problems of providing Medicaid services to welfare recipients.
9. Approved the following steps toward solving Medicaid problems:
  - (A) Continue rigorous negotiations to assure that agreements reached with IDPA are in fact implemented.
  - (B) Seek immediate removal of the Illinois Department of Public Aid's odious and unfair regulation permitting IDPA to judge the completeness of physicians' records for the purposes of payment or recoupment of payments previously made. ISMS shall seek to accomplish this using legal means, if necessary, recognizing that the Society is talking about reasonable numbers of missing records and is referring to physicians who are undergoing routine fiscal and quality of care audits.
  - (C) Reject the IDPA requirement that

physicians must determine if their public aid patients have any other resources available for payment for services rendered, stating clearly that it is not the legal nor moral responsibility of the provider to undertake such tasks.

- (D) Offer whatever assistance is necessary to bring the IDPA Physician's Handbook codes and billing form into compliance with the AMA's Current Procedural Terminology, Edition IV.
  - (E) Forward the Government Health Program Reimbursement Committee's recommendation re: Conformance of IDPA's Physician's Handbook and CPT IV Coding Procedure, through usual channels to the State Medical Advisory Committee for review and comment.
  - (F) Request IDPA to cease and desist from retrospective fiscal audits based on the present code definitions contained in the Physician's Handbook.
  - (G) Encourage IDPA to continue its efforts to curtail and uncover fraud within the Medicaid program.
  - (H) Re-evaluate ISMS policy which encourages physician participation in the Medicaid program if negotiations fail to satisfactorily resolve the problems regarding administration of Medicaid and payments are less than current usual and customary charges.
10. Rejected a proposal to prohibit members of the State Medical Advisory Committee from serving on the ISMS Governmental Health Program Reimbursement Committee, stating that such dual membership increases ISMS liaison with IDPA.
  11. Rejected a proposal that IDPA officials not be invited to participate in House of Delegates functions or in reference committee hearings.

## REFERENCE COMMITTEE C

1. Urged the Department of Mental Health and Developmental Disabilities to allocate state funds for the continuing education of physicians employed by its various mental health centers and utilize the services provided by the Illinois Council on Continuing Medical Education, including its publications, workshops, informal advice and the Illinois Hospital CME Consultation

Service.

2. Referred to the Board of Trustees for study and report back to the House its recommendations regarding a proposed policy favoring admission of students into medical schools on the strength of individual ability and on a non-discriminatory basis.
3. Approved re-allocation of \$10 of each member's 1978 dues normally allocated to AMA-ERF to the Illinois Council on Continuing Medical Education for use in activities as determined by its Board of Directors. In addition, the Reference Committee: (a) Urged ICCME to present a detailed identification of its budget needs at the next annual meeting; and (B) Recommended that the Liaison Committee to ICCME consider additional funding or funding mechanisms through appropriate exploration and development.
4. Rejected resolutions calling for mandatory publication in *IMJ* and *Action Report* of articles and advertisements on public aid problems submitted by members.

## REFERENCE COMMITTEE D

1. Agreed to petition AMA—through its World Health Organization delegates and our United Nations representative—to: (A) Require generic name, brand name or chemical composition on all drugs transported by patients crossing international borders; and (B) Require border inspectors to honor this request by international agreements so that U.S. doctors will be aware of the chemical composition of drugs obtained by their patients outside the country. AMA also will be urged to develop a document to allow for the cross-checking of chemical generic and brand names of drugs used in various countries.
2. Referred to the Board of Trustees to implement through the new Task Force on Cost Containment a recommendation that ISMS encourage an awareness of its members to the cost of hospital services, supplies and drugs.
3. Encouraged formation of standing committees composed of representative officers from county medical societies and local hospital staffs to guarantee a free-flow of information regarding activities of hospitals, medical organizations, governmental and quasi-governmental agencies in their community.
4. Adopted the following definition of peer

review:

"Peer review is the evaluation by practicing physicians of the quality, appropriateness and efficiency of services ordered or performed by other practicing physicians. It is the all-inclusive term for medical review efforts including utilization review, quality of care, competence determination and ethical considerations. Medical society peer review shall be conducted at the local level whenever possible."

5. Directed the Committee on Constitution and Bylaws to prepare, publish and submit to the next meeting of the House of Delegates appropriate bylaw changes in all places necessary so that appeals concerning a component society member for any reason be limited to matters of due process with a provision for the introduction of new information.
6. Ordered further Bylaws amendments to reflect the intent of component medical societies to conduct peer review on all physicians who are engaged in the practice of medicine within their jurisdiction, and directed the Illinois Delegation to the AMA to submit this concept to the AMA for applicability to the interstate medical community. Another resolution, which would allow ISMS to continue fee-adjudication, was rejected.
7. Adopted a policy that physicians licensed to practice medicine in all its branches remain the primary entry point for the care of patients with hearing impairment and that ISMS favors continued physician supervision and treatment of hearing, speech and equilibratory disorders. The Illinois Delegation to the AMA was requested to present this resolution to the AMA House of Delegates.
8. Reaffirmed endorsement of Current Procedural Terminology, Edition IV, directed ISMS publications to promote its use by Illinois physicians, and directed Illinois delegates to AMA to prepare a similar resolution for presentation to the AMA House of Delegates.
9. Adopted a policy which states the term "physician," may only be applied to one who has equivalent qualifications of a "physician licensed to practice medicine in all its branches," and that our goal should be that this definition be made a part of the Medical Practice Act.

## REFERENCE COMMITTEE E

1. Reiterated its objections to random substitution of prescription products, but authorized the Board of Trustees to seek these amendments to a generic drug substitution bill if passage of such a bill becomes imminent:
  - (A) Two signature lines printed on all physician prescription blanks, one labeled "FDA approved therapeutic equivalent drug may be substituted" and the other labeled "Do Not Substitute."
  - (B) Only drugs certified by the FDA and listed in the Pharmacopeia may be substituted.
  - (C) The pharmacist shall reduce the price to the consumer, of the drug dispensed, by the amount of the difference in the pharmacist's actual acquisition cost between the drug dispensed and the drug prescribed.
  - (D) The pharmacist notes on the prescription form the name and address of the manufacturer of the drug substitute and the actual acquisition cost of the drug dispensed.
  - (E) The patient is informed of and provides written approval for the substitution.
  - (F) The pharmacist notes on the label of the prescription dispensed to the patient the name of the manufacturer of the drug dispensed.
  - (G) The pharmacist assumes liability for any injury that may occur as a result of any substitution.
2. Adopted a policy on Death with Dignity legislation indicating that "ISMS will continue to oppose death with dignity, right to die and similar legislation, based on what must necessarily be a private matter between physician and patient."
3. Encouraged physicians to educate their patients to understand the plan of care proposed; opposed any legislation which would require "ritual" informed consent; and directed continued ISMS exploration of current applications of informed consent with the intent of identifying alternative mechanisms for obtaining consent in a reasoned fashion.
4. Rejected a proposal for ISMS to support decriminalization of possession of reasonably small amounts of marijuana for per-

sonal use, thus removing criminal penalties while assessing civil penalties.

5. Rejected a resolution urging ISMS to solicit Illinois Congressmen to initiate or support either the enactment of a statute extending the protection of the Constitution to all stages of human life or the proposal of a Constitutional amendment which will protect all human life, including the unborn.
6. Rejected two resolutions which would have encouraged continued use of limited license physicians in the state's mental hospitals.
7. Referred to the Board of Trustees—for the further guidance of the Task Force on Professional Liability—a resolution calling for statutory correction of attorney abuses which have contributed to the dilemma of Illinois courts and the professional malpractice problem.

## REFERENCE COMMITTEE F

1. Adopted the position that ISMS is opposed to compulsory governmentally-mandated national health insurance plans.
2. Rejected four resolutions calling for the end of ISMS unified membership with AMA.
3. Rejected two resolutions which would have rescinded existing ISMS policy binding members to AMA policy.
4. Rejected a proposal to establish an ad hoc committee to study the health care system of Illinois and to develop a plan for preserving it through private enterprise. The House was informed that the intent of the resolution is incorporated in recent Board of Trustees' action regarding cost containment.
5. Adopted the policy that membership shall have been properly informed on any matter when the following have been accomplished:
  - (A) Official notice in the *Illinois Medical Journal*.
  - (B) Brief notice in *Action Report*, outlining the issue and calling attention to the *IMJ* article.
  - (C) A letter sent to all county society presidents, secretaries and county executives.
6. Directed immediate dissemination of the packet entitled, "The Drift Toward a National Health Service," to all component medical societies for instant action in in-

forming the general public. It also directed that this educational drive be expanded so that legislators are fully informed of the medical profession's opinions on these matters and that the general public be made aware of the consequences of such a drift toward a national health service.

7. Adopted the following policy regarding expert medical witnesses in professional liability cases:

(A) An expert medical witness is defined as a physician licensed to practice medicine in all its branches having a basic educational and professional knowledge as a general foundation for testimony and, in addition, has special expertise, current personal experience, practical familiarity, and technical knowledge of the problems that are being considered, as well as alternative forms of treatment, and who is currently active in the practice of the medical subject under discussion.

(B) Any physician licensed to practice medicine in all its branches who functions as an expert medical witness, must satisfy the definition of an expert witness, that the definition be a matter of policy, and that it be considered unethical conduct on the part of any physician appearing as an expert witness who does not meet this standard.

The policy is to be recommended to the AMA House of Delegates for use by component medical societies and the AMA Task Force on Professional Liability and considered for incorporation into formal proposals for reforms needed to counter the professional liability crisis.

8. Adopted the policy that ISMS funds used by members campaigning for election as AMA officers, trustees or members of councils or committees must be approved by the ISMS Board of Trustees before such funds are spent for election campaign purposes.

## REFERENCE COMMITTEE G

1. Rescinded action of the 1976 Interim House of Delegates which made the Illinois Foundation for Medical Care "completely accountable only to the House of Delegates



through the Board of Trustees of ISMS and to each component society." In its place, it adopted the following policy:

- (A) The Illinois Foundation for Medical Care policy and philosophical decisions shall be made by the ISMS House of Delegates.
  - (B) IFMC is directed to be responsive to the needs of the local foundations for medical care.
  - (C) IFMC shall employ a full-time foundation administrator named by the IFMC Executive Committee and responsible to the president of IFMC and ISMS Board of Trustees.
2. Directed IFMC (A) Not to renew the current HASP contract and immediately enter into renegotiation with IDPA for the continuing HASP function and the termination phase of that program on a fiscally sound basis; and (B) To consider statewide programs related to health care delivery, with such programs then being implemented through negotiation with a qualified physician's organization designated by a component medical society or group of such societies.

3. Rejected a resolution that would have prohibited the ISMS Board of Trustees from providing IFMC with any further funding. It was pointed out that some short term advances of funds may be required to fulfill the remaining HASP contract.
4. Rejected a resolution that would prohibit IFMC, through ISMS, from involving county societies in any organizational plan for the delivery or financing of health care.

### UNREFERRED ACTION

1. Declared its opposition to President Carter's legislative initiative to control hospital costs and physician's fees and reaffirmed its faith in the private enterprise system.
2. Ordered appointment of a committee—consisting of the ISMS Executive Committee chairman, the IFMC Executive Committee chairman, and one representative of each local foundation for medical care to discuss and determine the needs of local foundations for medical care and the services which would be provided by the IFMC. The committee was directed to report at the next session of the House of Delegates.

## LOW-COST GROUP INSURANCE ANOTHER ISMS MEMBERSHIP PRIVILEGE

FOR INFORMATION,  
ASSISTANCE  
& DETAILS CONTACT:

Administrators:

**PARKER, AUSAIRE & COMPANY**  
ESTABLISHED 1901  
*Insurance*

**THE GROUP DISABILITY PLAN** ● Provides up to \$1,732.00 monthly in the event of disability caused by Accident or Sickness. ● Special Guaranteed renewal feature. ● Protect your income and security.

**BUSINESS OVERHEAD EXPENSE PLAN** ● Pays your office overhead expense when disability strikes. ● Premiums are Tax Deductible. ● Pays in Addition to the Disability Plan Benefits.

**THE BASIC MAJOR MEDICAL EXPENSE PLAN** ● In or out of Hospital Benefits up to \$25,000.00 per Disability. ● Up to \$100.00 Daily Hospital Room and Board maximum. ● Subject to choice of deductible and 80% coinsurance.

**EXCESS MAJOR MEDICAL PLAN** ● Provides up to \$250,000 for Medical Expenses. ● Supplements any Basic Major Medical Plan and has a \$25,000 deductible. ● Low group rates. ● Truly catastrophic coverage.

9933 N. Lawler Avenue  
Skokie, Illinois 60076  
Phone: 312-679-1000

# Actions on Resolutions

## April, 1977 Annual Meeting

### House of Delegates

<i>Number</i>	<i>Introduced By:</i>	<i>Subject</i>	<i>Action</i>
<b>Reference Committee on Constitution &amp; Bylaws</b>			
77A-1	Paul Stromborg	Amendment to Chapter IV, Section 11, of the Bylaws	Adopted as editorially changed
77A-30	Fred Z. White	Amendment to Article X of the Constitution	Approved for Consideration at 1978 Annual Meeting
77A-32	Fred Z. White	Amendments to Chapter I, II and X of the Bylaws	Adopted as amended
77A-33	Fred Z. White	Amendment to Chapter I, Section 1C of the Bylaws	Adopted as amended
77A-34	Fred Z. White	Amendments to Chapter IV of the Bylaws	Adopted as editorially changed
77A-43	Fred Z. White	Amendment to Article VI of the Constitution	Approved for Consideration at 1978 Annual Meeting
77A-46	Herschel Browns	Definition of Immoral and Gross Misconduct	Referred to B of T to Implement Intent of Resolution & Report Back to 1977 Interim Meeting
77A-108	Joseph Bordenave	Amendment to Chapter IX of the Bylaws	Adopted as amended
<b>Reference Committee "A"</b>			
77A-22	William Ackley	New ISMS Offices	Rejected
77A-39	George Lagorio	Future of the ISMS	Substitute adopted
77A-42	George Lagorio	H of D Fairness	Rejected
77A-52	William Frymark	Committee on Redistricting of the ISMS	Rejected
77A-96	George Mitchell	Downstate ISMS Office	Adopted as amended & editorially changed
77A-98	George Mitchell	Policy Statement by ISMS Officers, Trustees, Members of AMA Delegation	Referred to B of T to report back to 1977 Interim Meeting

<i>Number</i>	<i>Introduced By:</i>	<i>Subject</i>	<i>Action</i>
---------------	-----------------------	----------------	---------------

#### **Reference Committee "B"**

77A-36	James Sutherland	Medicare Part B Payments & Physician Profiles	Substitute adopted as amended
77A-62*	Raymond DesRosiers	Old Problems	Substitute adopted as amended

\*Adoption of Substitute 77A-62 satisfies the issues expressed in the remaining resolutions dealing with administration of Medicaid. Those resolution (77A-63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 83, 84, 85, 86, 89, 94, 101, 111, 112, 113, 114, 115 and 116) are referred to the Governmental Health Program Reimbursement Committee for information.

77A-81	Finley Brown	Payment for Work Performed	Substitute adopted
77A-82	Finley Brown	Avoidance of Conflict of Interest	Rejected
77A-87	Finley Brown	Crisis in Obstetrical Care	Adopted as amended
77A-88	Finley Brown	Injectable Drug Non-Payments	Adopted
77A-90	Finley Brown	Laboratory Tests	Substitute adopted as editorially changed
77A-91	Finley Brown	More False Promises from Politicians	Substitute adopted as editorially changed
77A-92	Finley Brown	Fox in the Chicken Yard	Rejected
77A-93	Finley Brown	Privately Run State Medicaid	Adopted as amended
77A-110	George T. Wilkins	Commendation of Robert R. Hartman, M.D.	Adopted

#### **Reference Committee "C"**

77A-3	George Lagorio	Public Aid Resolution	Rejected
77A-4	George Lagorio	Advertising	Rejected
77A-26	William M. Lees	Continuing Medical Education in State Mental Health Facilities	Adopted as editorially changed
77A-28	Ross Hutchison	Discrimination in Medical School Admissions	Referred to B of T and Report Back to House Next Meeting
77A-58	William M. Lees	Continued Funding for ICCME	Adopted

#### **Reference Committee "D"**

77A-2	C. J. Jannings, III	Generic Labeling for Drugs Crossing International Borders	Substitute adopted
77A-18	Joseph O'Donnell	Posting of Prices of Hospital Services, Supplies & Drugs	Substitute adopted as amended
77A-19	Joseph O'Donnell	Committee of County Society with Medical Staff Officers	Substitute adopted

<i>Number</i>	<i>Introduced By:</i>	<i>Subject</i>	<i>Action</i>
---------------	-----------------------	----------------	---------------

#### **Reference Committee "D" (Con't)**

77A-20	Joseph O'Donnell	Peer Review Fee Adjudication Appeals	Rejected
77A-29	Joseph Bordenave	Definition of Peer Review	Adopted as amended
77A-59	George T. Wilkins	Treatment of Persons with Hearing Disorders	Adopted
77A-60	Lawrence L. Hirsch,	Appeals Procedure	Substitute adopted
77A-104	Robert J. Becker	Endorsement of CPT IV	Adopted
77A-105	Guy A. Pandola	Amendment to Chapter XI of the ISMS Bylaws	Substitute adopted
77A-117	Harry Darland	Use of the Term "Physician" Resolution 76N-57	Substitute adopted as amended

#### **Reference Committee "E"**

77A-23	Alfred Faber	Modifying Drug Anti- Substitution Law	Adopted as amended
77A-24	Julian Buser	Death with Dignity Legislation	Adopted as editorially changed
77A-25	Allan Goslin	Informed Consent	Adopted as editorially changed
77A-44	Joseph H. Skom	Marijuana	Rejected
77A-45	H. Frank Holman	Safeguarding Human Life	Rejected
77A-55	George Lagorio	Limited Permit Physician Resolution	Rejected
77A-57	George Lagorio	Limited License Physicians in the Department of Mental Health	Rejected
77A-95	Wayne Leimbach	Legislative Direction to the Illinois Court System, A Necessary Step in the Correction of the Professional Malpractice Problem in Illinois	Referred to the B of T

#### **Reference Committee "F"**

77A-9	E. C. Bone	Preservation of Health Care System through Private Enterprise	Rejected
77A-27	P. John Seward	Informing the Membership	Adopted as editorially changed
77A-31	Carlos Lara	Strong Opposition to National Health Insurance	Substitute adopted as editorially changed
77A-35	James Sutherland	Failure to Implement Resolution 76N-59—Provision of a Task Force for Public Relations	Adopted
77A-37	Danford Chamberlain	Disaffiliation with AMA	Rejected



<i>Number</i>	<i>Introduced By:</i>	<i>Subject</i>	<i>Action</i>
---------------	-----------------------	----------------	---------------

### **Reference Committee "F" (Con't)**

77A-47	David Fox	Ethical Standard for Definition of Expert Witness	Adopted as editorially changed
77A-48	J. M. Ingalls	Use of ISMS Funds for AMA Campaigns	Adopted as amended
77A-49	James Laidlaw	ISMS House of Delegates Policy	Rejected
77A-50	James Laidlaw	Unified Membership with the AMA	Rejected
77A-51	James Sutherland	Cooperation with the AMA on National Health Insurance	Rejected
77A-102	J. Schrod	Unified Membership	Rejected
77A-103	D. Statzer	Setting of Policy by House of Delegates	Rejected
77A-106	W. A. Plassman	Unified Membership with AMA	Rejected

### **Reference Committee "G"**

77A-21	A. B. Johnson C. L. Flanagan	Resolution 76N-64	Substitute adopted as amended
77A-61	J. L. Bordenave Allan Goslin J. M. Ingalls	Future Role of IFMC	Adopted as amended
77A-97	G. T. Mitchell	Further Funding of IFMC	Rejected
77A-99	A. B. Johnson	Government Interference in Medicine	Rejected

### **Adopted Without Reference**

77A-118	George Wilkins	Governmental Control	Adopted
---------	----------------	----------------------	---------

### **House Action**

Motion from floor	Andrew Brislen	IFMC Committee Re: Needs of LFCMs	Motion carried
-------------------	----------------	-----------------------------------	----------------



# IMPAC

## ILLINOIS MEDICAL POLITICAL ACTION COMMITTEE

55 East Monroe Street  
Chicago, Illinois 60603  
312/782-1963

On behalf of the IMPAC Council, I would like to take this opportunity to thank all of those who attended the IMPAC/AMPAC Workshop during the ISMS Annual Meeting. I believe that we all learned more about the political process and at the same time, enjoyed our continued education.

In addition, I was pleased to learn that some of you decided to join IMPAC while attending the Workshop. Not only did we have new members join our ranks, but a number of you decided to add to your commitment by becoming Sustaining Members. Again, our thanks.

I also want to ask those of you who have not yet joined IMPAC to add to the commitment made by many others and fill out the form below. Your support makes medicine's total commitment complete.

*Pam Taylor*

Mrs. Pam Taylor  
Chairman

### IMPAC/AMPAC Membership

(check one)

- ☐ Sustaining .....\$99  
☐ Family .....\$45  
☐ Regular .....\$25  
☐ Auxiliary .....\$20

Return to:

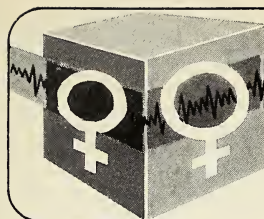
IMPAC  
55 E. Monroe Street  
Suite 3510  
Chicago, Illinois 60630

NAME \_\_\_\_\_ PHONE \_\_\_\_\_

ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ ZIP \_\_\_\_\_

Contributions are not limited to the suggested amount. Neither the Illinois State Medical Society nor the AMA will favor or disadvantage anyone based upon the amounts of or failure to make pac contributions. Copies of IMPAC & AMPAC reports are filed with the Federal Election Commission, Washington, D.C. Contributions are subject to the limitations of FEC regulations, Sections 110.1, 110.2 & 110.5. (Federal regulations require this notice.) IMPAC reports are also filed with the State Board of Elections, and are or will be available for purchase from the State Board of Elections, 1020 S. Spring St., Springfield, Illinois, 62704





## *pulse... of the doctor's wife*

MRS. EUGENE VICKERY, Editor

### KEY LINES:

## *Convention — A Time to Review*

BY BETTY SZEWCZYK, PRESIDENT, ISMSA

Liken it to a spring cleaning, or an annual inventory. We gather together our accomplishments, sources and resources, give them a good "eye", then either keep them safely for further use or if they don't pass our test for effectiveness and efficiency—out they go with the cobwebs!

The 49th Annual Meeting of ISMS Auxiliary was held at the Merchants & Manufacturers Club in Chicago, April 25-27, 1977. Immediate Past President Mrs. John Ovitz used Shakespeare's "The Past is Prologue" as a theme and it is most appropo. Every year should be a prelude to greater production in the future.

The Delegates' Handbook contained reports of the officers, councilors, board chairmen and all the county presidents. In addition, the county presidents were spotlighted as they gave two-minute oral reports, featuring their favorite projects of the year. Safety programs, particularly Heimlich Maneuver Posters and Water Safety Plaques, were very popular in most counties.

AMA-ERF rated close to the hearts of Illinois Medical Auxiliaries. On April 1, total contributions were \$21,699.09, with considerable more expected by the May 20 deadline. St. Clair County, with \$6,249.41 total and \$46 per capita, received the first award. Peoria and Winnebago were also honored.

Health Education-Health Manpower Awards went to Macon, Vermilion and Kane Counties.

Highest Percentage of Possible Members Awards were presented to Mercer, Warren, De-

Kalb, McLean and Peoria Counties. Winnebago was given a special award for thirty-eight new members.

Mrs. Charles Wunsch, Aurora, 1960-61 ISMS Auxiliary President, was the winner of the 1977 Humanitarian Award.

Mrs. John Ovitz presented President's Awards for outstanding service to Mrs. Robert Hartman, Mrs. John Sheen and Mrs. Jane Z. Swanson.

The annual meeting ended with the installation of the new officers for 1977-78:

President	Mrs. Edward Szweczyk
President-Elect	Mrs. Earl Klaren
1st Vice-Pres.	Mrs. William Hodges
2nd Vice-Pres.	Mrs. Alton Morris
3rd Vice-Pres.	Mrs. Harlan Faylor
Recording Secretary	Mrs. Stanley Burris
Corres. Secretary	Mrs. Julian Buser
Treasurer	Mrs. Robert Webb
Directors	Mrs. John Ovitz, Jr.
	Mrs. Donovan Stiegel
	Mrs. Frank Holman

Golden Anniversary Year 1977-78 Officers and Board are already at work sorting, filing and planning. Soon they will be presenting ideas to accomplish our goals for this coming year—including our special theme "Teach the Children." We will be articulating, motivating and communicating medical auxiliary. We want to be seen in our communities sharing and caring for health services and education.

**"The Past Is Prologue!"**



# AMA Challenges in the Courts

One of the professions's major concerns today is government's mounting pressure for increasing regulation of medicine. In response to these challenges, the AMA has taken a new position of advocacy for physicians and the public which has resulted in the AMA's very first lawsuits against the government.

In March 1975, the AMA took HEW to court over its Utilization Review Regulations which required review of all Medicare and Medicaid hospitalizations within 24 hours. The AMA contended the regulations constituted unlawful interference with the rights of physicians and patients. The AMA won its case and HEW withdrew the regulations.

The AMA also initiated legal action against

HEW's Maximum Allowable Cost Rule, charging that the rule, which would govern the prescription of drugs for Medicare and Medicaid patients, intrudes on clinical decisions made by physicians. The case is now pending.

The AMA has also joined with co-plaintiffs, the state of North Carolina, the state of Nebraska and the North Carolina Medical Society, in a suit against the Health Planning Act of 1974 which gives the Secretary of HEW sweeping powers over nearly every aspect of health care.

These are just some of the many actions the AMA has taken to protect your rights and interests and the rights and interests of your patients. With your support, it can be even more effective.



**Join us.**  
**We can do much more together.**

Dept. of Membership Development  
American Medical Association  
535 N. Dearborn St./Chicago, IL 60610

Please send me more information on the AMA and AMA membership.

Name

Address

City/State/Zip

## **Abstracts of Board Actions**

*(Continued from page 405)*

### **ISMS Retirement Program**

In its effort to phase out sponsorship of the ISMS retirement programs, the Board agreed to:

1. Maintain the present status of both programs (tax-qualified and non-tax qualified), but terminate Robinson Incorporated, as their broker-administrator.
2. Contract with CNA Insurance and Stein, Roe & Farnham (SRF) to service accounts of current participants directly or through ISMS offices.
3. Explore the advisability of a market survey to determine member interest in opening mutual fund to further participation. If a survey is deemed advisable, the Society will request SRF to conduct it.

### **Workman's Compensation**

The Dodson Insurance Group was authorized to mail a questionnaire to all ISMS members to determine the degree of interest in a sponsored program for workman's compensation insurance.

### **Impaired Physician Program**

The Board of Trustees approved a proposed mechanism to respond to the needs of physicians impaired by addiction to alcohol or other drugs. The mechanism—known as The Impaired Physicians Program—is based on a voluntary, non-punitive approach, with no reporting or sanctions involved.

Physician panelists—recruited from throughout the state—will be made known to the entire membership and the Auxiliary. They will be available to: (1) County medical societies and hospital staffs as resource persons, as well as for counseling physicians when they are deemed to be in need; (2) Medical Disciplinary Board when it wishes to refer a physician impaired by addiction; and (3) Families of addicted physicians.

### **IDPA Drug Manual**

The following drugs were approved for inclusion in the IDPA Drug Manual: Col Benemid, Darvocet N, Darvocet N-100, Minipress, Actifed C, Velosef (Cephadrine), Apresazide, Fiorinal with Codeine, Theophyl-225 tablets and elixir, Proxigel, and R & C Spray.

### **CME Accrediting Procedures**

The Board approved the following procedures for re-accrediting institutions for continuing medical education:

1. An "administrative extension" form would be issued to institutions automatically extending accredited status for six months beyond expiration date or until re-accreditation procedure is completed.
2. Effective date of accreditation would be retroactive to date of examiner's site visit and expiration date would be on the last day of the month of the accreditation term.
3. CME Accreditation Expiration Reminders would be sent at regular intervals beginning eight months in advance.

### **Student, Resident Business Sessions**

The Board approved use of the special one dollar assessment from dues to pay for: Lunch at the first annual meetings of the Student Business Session and Resident Physicians Section April 23; travel expenses for out-of-town students attending the first annual Student Business Session, and travel expenses for ISMS student and resident delegates and alternates who must travel out of town to attend meetings of the ISMS House of Delegates beginning with the 1977 annual meeting.

## Confidentiality and Peer Review Legislation

ISMS will seek legislation to safeguard the confidentiality of health care information and provide immunity for peer review activities and non-discoverability of peer review procedures. Any new legislative proposal on informed consent will be opposed unless it incorporates the reasonable man rule as established in Pennsylvania.

In addition to the previously accepted basic conditions which should be met by any bill dealing with confidentiality, ISMS will insist on inclusion of the following:

"A patient may authorize disclosure of personal health care information if he furnishes a signed and dated statement authorizing release in which he: (1) Authorized such disclosure for a specific period of time; (2) Identified the patient records which are to be disclosed; and (3) Specified the purpose for which, and the agencies or individuals to which, such records may be disclosed."

## Support of Legislation

ISMS will support:

- H.B. 168 —Creates the Public Smoking Act, designating specific areas where smoking is prohibited.
- H.B. 432 —Requires the Department of Public Aid to consider fees charged in a community to those not on public aid when negotiating fees with medical providers for public aid recipients.
- H.B. 484 —Amends the Act concerning liability relating to the use of human blood, organs, or tissue to change the self-repealing date from July 1, 1977 to July 1, 1979.
- H.B. 544 —Provides that physicians donating services to free medical clinics shall be immune from civil damages for acts or omissions, except for willful and wanton misconduct.
- H.B. 680 —Amends the Act concerning liability relating to the use of human blood, organs or tissue to change the self-repealing date from July 1, 1977 to July 1, 1981.
- H.B. 743 —New Act establishing a program for care of hemophilia under IDPH.
- H.B. 887 —Provides for licensing and regulation of ambulances, attendants and the companies which employ them, under jurisdiction of the Department of Public Health.
- H.B. 1105 —Requires employers to notify the appropriate license issuing authority of the discharge or suspension for reasons relating to competence of any employee who is a licensed health care professional.
- H.B. 1108 —Requires the Department of Public Health to report on hepatitis research programs every odd-numbered year (companion to H.B. 484 and H.B. 680).
- H.B. 1253 —Grants immunity from liability for any physician, association, society or person who in good faith reports that a physician is or may be in violation of the Medical Practice Act.
- H.B. 1290 —Prohibits filing of medical malpractice claims more than 2 years after the act.
- S.B. 427 —Expands the definitions under the Health Facilities Planning Act to include any building or facility licensed under the Clinical Laboratory Act.

ISMS will also support an amended version of the proposed Pharmacy Practice Act, conditional upon re-definition of "device", and will support HB 872, hypertension controls, if adequately amended.

H.B. 350—which prohibits advance payments for medical services, except for health maintenance organizations, prepayment plans under Social Security and insurance premiums—will be supported if amended to exempt the activities of any company or corporation serving as a management agent, or providing computer or other ancillary services related to medical care providers for the Department.

The Board voted to endorse, but not actively support HB 563, which provides that migrant workers may qualify for medical assistance under the Public Aid Code.

The Board referred the following to the Governmental Affairs Division to be supported, after consultation with legal counsel:

- H.B. 921 and S.B. 553 —Reimbursement of clinical social workers if amended to provide for patient examination by fully licensed physician.

S.B. 609 and H.B. 1367—Release of persons adjudged not guilty by reason of insanity, if appropriately amended so that mental condition of defendant is considered only at time of sentence rather than at determination of guilt or innocence.

## Opposition to Legislation

### ISMS will oppose:

- H.B. 156 —Creates the Patient Compensation Fund.
- H.B. 316 —Permits non-physicians to pierce ears.
- H.H. 445 —Permits registered nurses to diagnose and treat a common cold with drugs recognized for such treatment.
- H.B. 467 —Authorizes persons 18 or older to sign a statement indicating they do not want medical treatment and makes it unlawful for a physician or hospital to ignore the person's wishes. (Applies to treatments used to prolong life)
- H.B. 586 —Changes the definition of chiropractor under the Medical Disciplinary Act to mean "physician."
- H.B. 943 —Permits chiropractors to perform school physical exams.
- H.B. 944 —Permits chiropractors to perform exams for school athletic activities.
- H.B. 1070—Amends the Medical Practice Act to allow licensed physicians in all branches to qualify for the chiropractic examination.
- H.B. 1200—Prohibits hospital, clinics, nursing homes or other related institutions from restricting or prohibiting use of laetrile provided by the patient and administered.
- S.B. 350 —Amends Physician's Assistant Practice Act; expands scope of procedures which a physician's assistant can perform.
- S.B. 433 —Authorizes use of physician's assistants in teaching hospitals in excess of the one to one ratio to supervising physicians.

## Interim Committee for IFMC

Drs. Robert P. Johnson and Joseph Sherrick and Roger White were appointed an interim committee to act as "caretaker" for the Illinois Foundation for Medical Care until a new IFMC Board of Directors is elected.



**What the  
osteoarthritic  
patient  
perceives as  
“feeling better”..**

Please see last page of advertisement  
for summary of prescribing information.



## **Home Mailing List**

The Board of Trustees will allocate \$5,000 from the 1977 revised budget or the 1978 budget to obtain the home addresses of members and transfer them to mailing lists. The House of Delegates, at its 1976 interim session, authorized the compiling of such a membership roster to encourage physician involvement in political campaigns. The home address list will be restricted to special mailings.

## **Laetrile**

The Board of Trustees opposes the availability of Laetrile for general use until experimental evidence demonstrates efficacy and there has been approval of the appropriate agency of the federal government. ISMS has no objections to its availability for experimental use if labeled as an experimental IND drug.

## **Injections by Medical Assistants**

In response to an Illinois Department of Public Health inquiry regarding appropriateness of office personnel performing injections, the Board stated that in accordance with the traditions of medical practice—a person trained by a physician and working under supervision of the physician, may administer injections or draw blood, in keeping with physician's orders.

## **Recruitment and Placement of Physicians in Rural Communities**

ISMS will serve as a catalyst in the development of a task force, comprised of statewide organizations and medical schools, to study the problems of recruiting and placing physicians in rural communities in need of physicians and for practitioners trying to relocate in Illinois.

## **Areawide Hospital Emergency Service Committees and HSA's**

ISMS will urge the 11 Illinois Health Systems Agencies to work with their local Areawide Hospital Emergency Service Committees—comprised of physicians, nurses, hospital administrators and allied personnel—in the development of emergency medical service plans and other EMS activities.

## **Medical Information on Drivers' Licenses**

ISMS will support in principle a bill to permit the Secretary of State to place a symbol on a driver's license, at the driver's request, indicating that the driver is carrying important medical information. The secretary will be urged to work with ISMS in the design of the emergency medical information cards to be carried by drivers.

## **Categorization of Hospitals**

ISMS will request the Illinois Department of Public Health to re-evaluate the categorization of all Illinois hospitals to determine if each meets its designated level or wishes to modify the designation for emergency service capabilities.

## **Autogenous Urine Immunization Therapy**

The Board of Trustees opposes the current use of "autogenous urine immunization therapy" in the treatment of allergy and will inform the membership of its opposition through the Illinois Medical Journal and Action Report. The Council on Social and Medical Services informed the Board that it had reviewed all available material on this subject and remains unconvinced of the treatment's effectiveness.

### **Scoliosis Screening**

The Illinois Office of Education will be urged to include scoliosis screening in its yearly recommendations for school health programs in the state's public and private school systems.

### **Citizens Committee for an Illinois Program to Control High Blood Pressure**

ISMS will resume liaison with the Citizens Committee for an Illinois Program to Control High Blood Pressure, but will not co-sponsor the committee. Co-sponsorship was withdrawn last February to avoid giving the impression that ISMS supported its proposed legislation to create a state hypertension registry. The Board later was informed that the committee chose not to introduce such legislation. Dr. David Littman is ISMS representative to the committee.

### **Third Party Intervention in the Practice of Medicine**

The Board of Trustees has accepted the following proposals of the Health Insurance Association of America for eliminating the recurring problem of third party intervention into the practice of medicine:

1. HIAA will send memoranda to all its members calling attention to ISMS concerns and requesting appropriate action be taken.

2. HIAA's National Medical Relations Committee will work with ISMS to develop model correspondence on usual, customary and reasonable fees regarding the differential between physician's fees and the insurer's policy allowance.

3. ISMS will forward to HIAA all copies of future correspondence from carriers that interfere with the practice of medicine.

4. HIAA representatives will meet with the Council on Economics and Peer Review on an ongoing basis.

Accordingly, the Board agreed to take no legal action in this matter for the present.



**What the  
osteoarthritic  
patient  
perceives as  
“feeling better”..**

Please see last page of advertisement  
for summary of prescribing information.

## **Prudential Insurance Company**

The Board found unacceptable a Prudential Insurance Company model letter to be used when notifying a physician that the insured's policy does not cover the fee charged for the services provided. ISMS will request that a revised draft be submitted to the Council on Economics and Peer Review. The company's representatives will be invited to participate in the council's review.

## **Physician's Assistants**

The Board of Trustees reaffirmed its objections to a proposed modification of the state's definition of a physician's assistant. ISMS, therefore, will oppose any proposed amendment to the law which would make the definition commensurate with the Type A Physician's Assistant as defined by the Board of Medicine of the National Academy of Sciences.

However, the Board encouraged the Department of Registration and Education to replace its current P.A. licensing examination with the national certification exam, contingent upon an agreement that physician's assistants licensed under it would still be considered Type C physician's assistants.

## **Mental Health Code**

The Executive Committee and Chairman of the Board of Trustees were authorized to approve appropriate statements or positions developed by a special ISMS-Illinois Psychiatric Society Task Force regarding proposed revisions of the Mental Health Code. To allow time to study this complex matter, ISMS will support efforts to have a package of bills dealing with revisions in the code referred to a legislative study commission.

## **Professional Liability**

Because it is unable to obtain passage of a more suitable bill, ISMS will support legislation to limit the statute of limitations in professional liability cases to two years after occurrence with no provisions for minors.

The Illinois Delegation will introduce a resolution in the AMA House of Delegates urging AMA to: (1) Develop counter-litigation activities; (2) Encourage other state societies to follow Illinois' lead in this area; and (3) Take advantage of ISMS consulting services on a cost basis.

The ISMS Task Force on Professional Liability will launch a Risk Management and Loss Prevention educational program for ISMS members within the next few weeks. This program will include data collection, surveying exposure to risk sites, development of a technical manual and establishment of a speaker's bureau.

## **Interim Sessions of the House of Delegates**

Tentative locations for interim sessions of the House of Delegates are St. Louis, 1977; Rockford, 1978, and Decatur, 1979.

## **Board Meeting Schedule**

The Board of Trustees will meet June 4-5 and August 27-28 at the Marriott Motor Hotel in Chicago.

## **Dr. Fox Re-Elected**

Dr. Robert T. Fox, Glenview, was re-elected chairman of the Board of Trustees at its meeting following adjournment of the 1977 annual meeting of the House of Delegates.



## Board of Directors, Illinois State Medical Insurance Services

The Board re-elected Drs. Joseph Bordenave, Geneva; Alfred Clementi, Arlington Heights; J. M. Ingalls, Paris; Robert T. Fox, Glenview; Phillip D. Boren, Carmi, and Charles Schlageter, Chicago, and Mr. Roger N. White, ISMS Executive Administrator to the ISMS Board of Directors.

## Appointments, Nominations

The Board of Trustees made the following appointments and nominations:

*ISMS Public Affairs Committee*—Dr. Don E. Hinderliter, Rochelle, appointed to replace Dr. Tassos Nassos, Chicago, now chairman of Governmental Affairs Council.

*AMA Conference on Rural Health*—Dr. Audley F. Connor, Jr., Chicago, appointed ISMS representative to attend conference March 30-April 1 in Seattle, Wash.

*Statewide Health Coordinating Council*—William Coughlin, Roy Armstrong and Dr. Moham- med Akhter endorsed as candidates for executive secretary.

*Hospital Licensing Board*—Drs. William M. Lees, Lincolnwood, and Robert Reeder, West Chicago, nominated for appointment.

*Ambulatory Surgical Treatment Center*—Drs. Gwendolyn Schmidt, Chicago, and Edward Jesse Jacobs, Arlington Heights (reappointment) and Drs. Donald Jerome, Belleville, William McNabola, Elmwood Park, and William Donnellan, Arlington Heights, nominated for appointment.

*Medical Examining Committee*—Dr. Robert Behmer, Rockford, nominated as University of Illinois representative to the committee.

*AMA Councils*—Drs. John J. Ring, Mundelein, Council on Medical Service; Jack L. Gibbs, Canton, Council on Medical Education, and Theodore Grevas, Rock Island, Judicial Council nominations.

*Medical Advisory Committee to IDPA*—Drs. Earl Frederick and Lucius Earles, Chicago, nominated for appointment.



**What the  
osteoarthritic  
patient  
perceives as  
“feeling better”..**

Please see last page of advertisement  
for summary of prescribing information.





## report

Illinois Society  
American Association of Medical Assistants

### 1977 CONVENTION HIGHLIGHTS



From left to right: Leslie Lee, President-Elect, Vivian Kraft, President, Dr. John L. Wright, Chairman-Physician's Advisory Board, Ruby Jackson, Immediate Past President and Jeanne D. Green, President-Elect to A.A.M.A. National.

The 21st Annual Convention of the Illinois Society of the American Association of Medical Assistants was held April 28-May 1, 1977 at the Holiday Inn, Bradley, Illinois.

Mrs. Leslie Lee, Speaker of the House, officially convened the House of Delegates the morning of Friday, April 29th. Mr. James Slawny, Assistant Executive Administrator of the Illinois State Medical Society, welcomed the Illinois Society, A.A.M.A. and expressed, on behalf of I.S.M.S., their continued support of Illinois Society and it's educational goals. He also commended the Society for achieving a high standard of professionalism.

The new officers elected during this session of the House for the 1977-78 term were: Vivian Kraft, CMA-AC—President, (Bloomington), Leslie Lee—President-Elect (Chicago), Jean Lockenvitz—First Vice President (Bloomington), Sylvia Temple, CMA—Second Vice President (Charleston), Donna Keime—Recording Secretary (Cuba), Jean Fouts, LPN—Corresponding Secretary (Normal), Mary Frances Burton—Membership Secretary (Chicago) and Helen LaMore,

CMA—Treasurer (Manteno). Delegates to the A.A.M.A. National Convention in San Francisco, October 17-22, 1977 are: Vivian Kraft, Leslie Lee, Anna Albert (Chicago), and Cissy Moran, CMA (Joliet). Alternate delegates are: Magda Brown (Chicago), Phyllis Harwood, CMA-AC (Elgin), Bonnie Anderson, R.M.S. (Kankakee), and Patricia Mooney, R.N. (Peoria).

Dr. Carl E. Clark of Sycamore, Liaison to the Illinois State Medical Society, was unanimously elected to the Physician's Advisory Board. Norma Domanic, LPN (Joliet) was unanimously nominated by the House of Delegates as the Illinois Society's candidate for National Trustee at the A.A.M.A. National Convention in San Francisco in October 1977.

At the close of this session of the House Friday evening, Mrs. Leslie Lee submitted her resignation as Speaker of the House in order to fulfill her term as President-Elect. Mrs. Luella Mitchell, Vice Speaker (Chicago) became Speaker of the House for the remaining year of Mrs. Lee's two-year term.

Friday evening, Mrs. Ruby Jackson, CMA—Retiring President (Chicago), honored the Chapter Presidents and past State President's at the traditional President's Dinner. Dr. P. W. Sawyer, Advisor (Kankakee County Chapter) was the Master of Ceremonies for this event.

Continuing education sessions were held on Saturday, April 30th. All four sessions revolved around medico-legal issues and were of acute interest to all medical office assistants. The speakers in order of their presentations were: Walter S. Feldman, M.D., J.D., F.C.L.M., Mr. Joseph A. Koprowski, J.D., Mr. Ben C. Happach, C.C.C.E., C.M.P.A. and Robert J. Kramer, M.D., F.A.C.S. Continuing education units (CEU's) were awarded to members attending these sessions, upon successful completion of a short written exam.

Dr. John L. Wright of Bloomington, Chairman of the Physician's Advisory Board of Illinois Society, A.A.M.A., officiated during the Installation Banquet Saturday evening. He recognized the retiring 1976-77 officers and thanked them on behalf of the Illinois Society membership for a job well done during their term of office. Dr. Wright

then conducted the installation ceremony for the incoming officers of the 1977-78 term. Mrs. Ruby Jackson, Retiring President, extended her thanks to the membership and to her officers for their support during her administration and pledged her continuing support to the tri-level A.A.M.A. organization.

Mrs. Vivian Kraft, CMA-AC—President of Illinois Society, addressed the membership following the installation ceremony with a statement of goals during her term of office, which included more educational seminars for medical assistants and a membership goal of 1500 by April 1978.

Sunday, May 1st, Mrs. Jeanne D. Green, CMA (Iowa), President-Elect to National A.A.M.A., addressed the membership at the Farewell Breakfast. She stressed the importance of continuing education in the future of medical assisting and the need to become more aggressive in seeking certification.

The 21st Annual Convention of the Illinois Society, A.A.M.A. was officially closed with a reminder that Chicago will be the 1978 host at the new North Shore Hilton Hotel in Skokie, Illinois, April 27-30, 1978.

---

## ...you see as effectiveness

The relief of pain  
and stiffness  
in patients with  
osteoarthritis

The improvement  
in mobility  
in patients with  
osteoarthritis



# Nalfon®

fenoprofen calcium

Please see last page of advertisement for summary of prescribing information.

# Who Graduated This Spring?

BY JOANN MORETTI, MEDICAL ASSISTANT STUDENT  
TRITON COLLEGE, RIVER GROVE, ILLINOIS

Along with hundreds of thousands of other students, a very special group graduated this Spring: medical office assistants. The first question that is always asked of me is, "what is a medical office assistant?" The next question is always, "what has she been trained to do?" As a member of this graduating body, it is my privilege and honor to introduce them here and now.

A medical assistant is someone who wants to serve; someone who likes being with people. She is a combination secretary, nurse, X-ray assistant, EKG assistant, lab assistant, human relations expert, and generally, the physician's "right hand." Through her efforts, the doctor is able to concentrate his time on his patients. She is dedicated to the same principles and ethics that her employer follows.

She has spent two years in a school that is accredited by both the American Medical Association (A.M.A.) and the American Association of Medical Assistants (A.A.M.A.). She has "struggled" and "sweated" through physiology, lab procedures, microbiology, office procedures, medical ethics and law, psychology, pharmacology, and clinical office procedures. Upon graduation, she will receive an Associate in Science degree. Usually, she will be a member of a chapter of the American Association of Medical Assistants (A.A.M.A.). When she graduates, she will sit for her C.M.A. examination, a national proficiency test for medical assistants given by the A.A.M.A. Can she rest on her laurels now? No, she cannot! In order to retain her C.M.A. certification, she must continue her education, by attending lectures, workshops, and schools. Every five years she must present a required number of Continuing Education Units or lose her certification.

But above all this stands dedication to her physician/employer. She is there to assist him in every way she can. She tries to relieve him of the nonmedical burdens in his office. She realizes that just to keep up with the fast, changing medical profession requires a great deal of his time. She feels that there is no higher calling than the "art of healing" and wants her physician/employer to have more time to practice his "art". She is the link between her physician/employer and his patients. She tries always to be

understanding and empathic towards the many different types of people who seek out her physician/employer for help. She never sits in judgment when she handles their complaints. She has a real affection for them as human beings, who need aid.

So, this then, is what a medical assistant is and what she has been trained to do. I congratulate the good judgement of those physicians who have a medical assistant working in their offices, and also those who are thinking of hiring a medical assistant. And to all those medical assistants who graduated this May, I would like to say I am proud to be one among you, that I hope I have all the qualities of a good medical assistant, and I want to take this opportunity to salute you on your many accomplishments. Physicians, everywhere, meet your future office staff!

## COOK COUNTY

### Graduate School of Medicine

#### CONTINUING EDUCATION COURSES STARTING DATES - 1977

RADIATION ONCOLOGY, Four and a half days, June 1  
ADVANCED CARDIOLOGY, One Week, June 6  
MANAGEMENT OF COMPLICATIONS IN SURGERY, June 6  
ADVANCED PERIPHERAL VASCULAR SURGERY, July 18  
SPECIALTY REVIEW FAMILY PRACTICE, August 15  
SPECIALTY REVIEW ORTHOPAEDICS, August 31  
QUALITY ASSURANCE EVALUATION, Three days, September 8  
SPECIALTY REVIEW ENDOCRINOLOGY, September 12  
SPECIALTY REVIEW MEDICAL ONCOLOGY, September 12  
SPECIALTY REVIEW GASTROENTEROLOGY, September 12  
STATE & NAT'L. BD. REV., BASIC, September 25,  
CLINICAL, Oct. 3  
SPECIALTY REVIEW CARDIOVASCULAR DISEASE, September 26  
GYNECOLOGIC PATHOLOGY, One Week, September 26  
FLUIDS AND ELECTROLYTES, One Week, September 26  
BASIC ELECTROCARDIOGRAPHY, One Week, October 3  
EKG FOR ANESTHESIOLOGISTS, One Week, October 3  
BASIC DERMATOLOGY, One Week, October 10

*Information concerning numerous other continuation courses available upon request.*

Address:  
REGISTRAR, 707 South Wood Street,  
Chicago, Ill. 60612

## Identify with the Success of Oak Brook

### *Oak Brook Office Plaza*

*Lease applications now being  
taken for individual floors  
consisting of 3600 sq. ft. or  
an entire building of 7200 sq. ft.*

*Consult: Paul Shukis*

**RICH PORT, REALTOR®**

*Commercial Investment Division*

*2100 Clearwater Drive*

*Oak Brook, Illinois 60521*

*312-654-4100*

## Obituaries

\*Anderson, Enor G., Rockford, died in April of this year at the age of 75. Doctor Anderson was a 1928 graduate of Washington University Medical School, St. Louis.

\*Cohen, Kenneth, Wilmette, died April 29th at the age of 47. Doctor Cohen was a 1955 graduate of the University of Illinois College of Medicine.

\*\*Cox, H. Hoyt, LaSalle, died this year at the age of 90. Doctor Cox was a 1916 graduate of Rush Medical College.

\*\*Hough, Charles S., Chicago, died May 2nd at the age of 90. Doctor Hough was a 1928 graduate of Meharry Medical College, Nashville, Tennessee.

\*Jacobson, Herman A., Chicago, died April 25 at the age of 72. Doctor Jacobson was a 1928 graduate of the University of Chicago, Pritzker School of Medicine.

\*Kapernick, John S., Decatur, died May 1 at the age of 67. Doctor Kapernick was a 1937 graduate of the University of Illinois College of Medicine.

\*\*Roth, John B., Sr., Morris, died April 29th at the age of 66. Doctor Roth was a 1934 graduate of the University of Illinois College of Medicine.

\*\*Ward, Benjamin F., Ft. Lauderdale, Florida, (formerly of Cicero) died March 13th at the age of 91. Doctor Ward was a 1919 graduate of the Loyola University Stritch School of Medicine.

\*Indicates ISMS member.

\*\*Indicates member of the ISMS Fifty Year Club.

## EKG

*(Continued from page 424)*

**Answers: 1. B,C,D 2. B**

Aberrant intraventricular conduction is reasonably common especially in the presence of atrial fibrillation, but can be difficult and occasionally impossible to diagnose. This patient developed post-operative pericardiotomy syndrome with atrial fibrillation and chest pain. The ST segment elevation or current of injury is due to pericarditis. The ventricular response to the atrial fibrillation was rapid. The irregularity of the R-R cycles set the stage for aberrant intraventricular conduction. There are several clues that can be used to help differentiate aberrancy from ventricular ectopy. The coupling interval of the bizarre beats was not fixed and varied from 280 to 380 msec. Fixed coupling intervals would favor the diagnosis of ventricular ectopy. As one follows the continuous rhythm strip, it can be seen that there is no suggestion of a compensatory pause following the paroxysms of bizarre beats. Even in atrial fibrillation, one

would expect some compensatory pause with premature ventricular beats. The initial portion of the QRS of the wide QRS beats is the same as the normally conducted beats. The delay in the QRS of the wide QRS beats is seen in the terminal portion of the QRS. This suggests that the delay in conduction causing the aberrancy is in the right bundle branch. Normally, the refractory period of the right bundle branch is greater than the left bundle branch. This is the reason that most aberrantly conducted beats resemble right bundle branch block for one or more beats. Finally, examination of the two cycles preceding the aberrantly conducted beats frequently demonstrates a long cycle to short cycle combination unless the cycles are both less than 380 msec. Aberrant intraventricular conduction often occurs when one impulse to the ventricles is followed by a second impulse by less than 400 msec. The treatment of the arrhythmia is digitalis since controlling and slowing the ventricular response in atrial fibrillation will cause the aberrancy to disappear. The patient's post-operative pericarditis responded to small doses of Prednisone. He is well and working since thirty months in follow-up. There has been no recurrence of atrial fibrillation.



# Physician Recruitment Program

*In an effort to reduce the number of towns in Illinois needing physicians, the Physician Recruitment Program and the Doctor's Job Fair, are publishing synopses in the Journal.*

*Physicians who are seeking a place to practice or who know of any out-of-state physicians seeking an Illinois residence are asked to notify the Program.*

*Any areas wishing to be listed should contact: Mrs. E. Duffy, Physician Recruitment Program, ISMS, 55 E. Monroe, Suite 3510, Chicago, 60603.*

**ARCOLA:** F.P. or G.P. needed to join only physician in true rural community (2,300 population). Must be willing to do O.B. Ultimate plans for new 3-man clinic. Close to beautiful county hospital less than 10 years old. Robert N. Arrol, M.D., 126 S. Locust, Arcola, Illinois 61910. (217) 268-4444 or (217) 268-4404. (10)

**BEMENT:** Population around 1800. Take over established practice of 30 years. Complete office facilities. Financial assistance available. New nursing home. New hospital and nursing home 7 miles. Located 25 miles from Decatur, 30 miles from Champaign hospitals. Choice of newly decorated home city or country. Contact: Mayor J. E. Hargrave, 633 E. Bodman, Bement, 217-678-8186 or Dr. Wm. Scott, 107 E. Bodman, Bement, 217-678-5151. (9)

**CANTON:** Clinic established in 1937 serving the Spoon River Valley area. This multi-specialty clinic is located in a clinic building constructed in 1969, located two blocks from 250-bed hospital. Twelve physician group. 30 miles from Peoria School of Medicine. Contact: Harlan Crouch, 175 S. Main, Canton, 61520. 309-647-0201. (8)

**CARBONDALE:** Family Physician: Innovative neighborhood center in Southern Illinois seeks family practice physician to provide patient care and supervise other professionals and paraprofessionals in a clinic setting. Salary negotiable. Position available March, 1977. Contact: Robert Stalls, Director of Human Resources, City of Carbondale, 609 E. College, Carbondale, (618-549-5302). (6)

**CHICAGO:** Progressive Community Hospital with active Emergency Department seeking an Orthopedic Surgeon. Good facilities available. Financial package attractive. Contact: Joel V. Bailey, 326 West 64th Street, Chicago 60621—312-962-4100. (8)

**CHICAGO** (desirable suburb): Older general practitioner has excellent office facilities to share with

younger G.P. Objective: need help with practice. Younger man may have guarantee to take over practice in near future. Hospital staff appointment available. All replies confidential. Box MK, Physician Recruitment Program, ISMS. (9)

**CHICAGO:** Take over large general practice. No investment required. Modern fully equipped and staffed facility. Salary and profit sharing. Contact: Jack Pardee, Suite 300, 2400 E. Devon, Des Plaines 60018. 312-298-3500. (9)

**CHICAGO:** Medical Center with complete facilities needs physician full time for welfare practice. Part time hours are also available. Above average earnings obtainable. Contact: Mohawk Medical Center, 832 West Madison Street, Chicago, Illinois 60607. (312) 421-2199. (9)

**EAST CHICAGO:** Large industrial facility located in northwestern Indiana has an immediate opening for a medical director. You will supervise a medical facility and experienced staff and play an active role on the management team. The position offers excellent salary and fringe benefits. M.D. required. An equal opportunity employer-M/F. Please reply to: Box MW, Physician Recruitment Program, ISMS. (9)

**FAIRBURY:** population 3,500; fully accredited modern hospital in progressive rural community located 100 miles southwest of Chicago servicing 15,000. Housing, office, and financial assistance available. Only five general practitioners and one board eligible surgeon serving area. Contact Donald Patterson, Administrator; Fairbury Hospital, 519 South Fifth Street, Fairbury, 61739, (815) 692-2346. (8)

**GENESE0:** Physicians wanted for Family Practice, OB-Gyn, Pediatrics, Internal Medicine, General and Orthopedic Surgery. Attractive, prosperous, residential community of over 7,000; serving trade area of 35,000 population. Located on Interstate 80, 2½ hours from Chicago; 25 miles east of Quad Cities metropolitan

area of 350,000. Ideal, safe, small city living with excellent recreational facilities. New ultra modern hospital with 110 beds. New modern doctor's offices and housing on hospital property immediately available. Attractive financial arrangements include guarantee. Contact Physician Recruitment Committee, 210 W. Elk St., Geneseo, 61254 or phone collect; G. L. Wissink, Administrator (309) 944-6431. (10)

**HINSDALE:** Seeking physicians for church-related, fee-for-service, family health centers in Chicago western suburbs. Competitive salary, facilities, equipment, malpractice insurance included. Continuing education, patient education, counseling staff, teaching of medical students and residents. Contact Bill Peterson, Pastoral Director, Wholistic Health Center, 137 S. Garfield, Hinsdale, 60521. Phone (312) 986-5252. (9)

**KANKAKEE:** Physician needed for area-wide trauma center in a 300 bed hospital. Emergency Medical training or training in primary care medicine is required. Salary commensurate with training and experience. Please contact Dr. R. Schuller at 500 West Court Street, Kankakee, Illinois 60901 or phone 815-937-2410. (6)

**KEOKUK, IOWA:** Progressive industrial community of 15,000 with 40,000 service area. Opportunities for family practice and internal medicine, solo or group practice. Complete office facilities, financial guarantee and assistance available. Located on Mighty Mississippi. Contact: Dr. Lynn L. Walker, Keokuk Area Hospital, P.O. Box 1500, Keokuk, Iowa 52632. AC 319-524-7150. (9)

**LaSALLE-PERU:** Board certified or eligible anesthesiologists to head department in North-Central Illinois hospital serving 35,000 area population. Four CRNA's currently on staff. Located two hours from Chicago, this area offers recreational facilities, good schools and housing. Contact W. T. Schweickert, Administrator, 925 West St., Peru, 61354. 815-223-3300. (10)

**LIBERTYVILLE:** Family practice physician, G.P. or internist to join new outpatient clinic consisting of full auxiliary facilities, special procedure rooms and future outpatient surgical center. Located in a rapidly growing area near lakes, shopping centers, recreation areas and easy access to Chicago theaters, museums and cultural events. For information call 312-362-0020, write Dr. G. Gavary, 611 S. Milwaukee, Libertyville, 60048. (9)

**MURPHYSBORO:** Board certified or eligible, one pediatrician, one surgeon; to join a solo OBS-GYN in a progressive community hospital. Enjoy golf, deer hunting, fishing, water sports in beautiful pollution free area. Guaranteed income, excellent fringe benefits with progressive increases and partnership in three years. Interested applicants contact: U. Matias, M.D. 618-687-1901 home, 618-687-3351 office. (10)

**OREGON:** Population 3800. Northern Illinois' most beautiful little town needs physician. On Rock River, two State Parks, 16 local industries. New Doctor with 3-year old practice would welcome associate. Great opportunity. Contact: Jean Davis, Etnyre Terrace, Oregon, 61061. Tel. 815-732-6248. (8)

**PEORIA:** Emergency Medicine Residency Program seeks faculty for positions beginning immediately and July 1, 1977. 850 bed university affiliated hospital located in Central Illinois. Regional Trauma Center with 45,000 undifferentiated ER patient visits annually. Positions combine academic and clinical responsibilities in developing residency program. Inquiries limited to certified/eligible primary care specialists (Internal Medicine, Pediatrics, Surgery) or graduates of ER residencies. Salary competitive with numerous fringes including malpractice. Send replies to Mr. Ronald Pechan, Assistant Administrator, St. Francis Hospital-Medical Center, 530 N.E. Glen Oak, Peoria, 61637. (309/672-2298). (8)

**PRINCETON:** New physicians offices under construction at Perry Memorial Hospital which serves Bureau County, population 40,000. Two hours southwest of Chicago. All recreational facilities available, good schools and comfortable living in country style. Contact John Revel, 606 South Main Street, Princeton, 61356. AC/815-875-4444. (6)

**ROCKFORD:** 250-bed hospital-Regional Trauma Center seeks Emergency Room Physician interested in EMS programs. New paramedic program; affiliated with Rockford School of Medicine. New emergency room facilities include x-ray capabilities; state-wide radio network; Poison Control Center; heliport. Second largest city in Illinois, located one hour west of Chicago and close to Wisconsin resort areas. Contact: Bob Flodin, St. Anthony Hospital Medical Center, 5666 East State Street, Rockford, 61101 (815) 226-2010. (10)

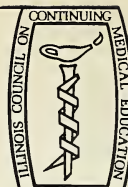
**SULLIVAN:** A new \$1,000,000 medical facility is looking for doctors in a midstate town of 4,000. It offers challenging positions for creative individuals to design and implement patient-care programs. Partnerships with established doctors also available. Three hospitals are within thirty miles. An 11,000 acre recreational lake is nearby. Contact: Bob Lemler, 200 S. Hamilton, Sullivan, 61951. 217-728-4311. (10)

**TUSCOLA:** Internist needed. Excellent hospital facilities. Located twenty miles from Champaign-Urbana and the University of Illinois campus. Financial assistance, office facilities available. Contact Norm Rentz, 704 N. Main St., Tuscola, 61953. (217) 253-3361. (10)

**WASHINGTON:** Population over 10,000. Physician recently moved to Florida. Three physicians at present. Eleven miles from Peoria's three hospitals and Peoria Medical School. Some financial aid available. Excellent schools, parks, etc. Contact: Dean R. Essig, 135 Washington Square, Washington, 61571. (309) 283-8041.

# ISMS Guide to Continuing Medical Education

Compiled for Illinois physicians by the  
ILLINOIS COUNCIL ON CONTINUING MEDICAL EDUCATION  
55 E. Monroe St., Suite 3510 • Chicago, IL 60603 • (312) 236-6110



Items for this Calendar must be received 90 days prior to the event. Those received earlier may appear in up to three monthly issues.

**WARNING!** Items for this Calendar come from many sources, often far in advance of the publication date. Sometimes, cancellations or changes in date, place or time occur too late to be corrected before publication. You are urged to contact the sponsoring organization to confirm information given below.

## JULY

### Family Therapy

**INTRODUCING FAMILY SYSTEMS (Introductory)**  
For: Physicians and Mental Health Practitioners. One-week course. July 11-15, 9:00 AM-3:30 PM Daily. Chicago. Speaker: Nancy Reed, ACSW. CME Credit: 35 hrs. AMA Cat. 1. Fee: \$130. Reg. Limit: 24. Sponsor, contact: The Family Institute of Chicago/Center for Family Studies, Ten East Huron, Chicago, IL 60611. Attn: Belinda Stone. Telephone: (312) 440-1414. Co-sponsors: Institute of Psychiatry, Northwestern Memorial Hospital and Northwestern University Medical School.

### Family Therapy

**THE PRACTICING FAMILY THERAPIST (Advanced)**  
For: Physicians and Mental Health Practitioners. One-week course. July 25-29, 9:00 AM-3:30 PM Daily. Chicago. Speaker: Lynn Parker Wahle, ACSW. CME Credit: 35 hrs. AMA Cat. 1. Fee: \$130. Reg. Limit: 20. Sponsor, contact: The Family Institute of Chicago/Center for Family Studies, Ten East Huron, Chicago, IL 60611. Attn: Belinda Stone. Telephone: (312) 440-1414. Co-sponsors: Institute of Psychiatry, Northwestern Memorial Hospital and Northwestern University Medical School.

### Family Therapy

**ON BECOMING A FAMILY THERAPIST (Intermediate)**  
For: Physicians and Mental Health Practitioners. One-week course. July 18-22, 9:00 AM-3:30 PM Daily. Chicago. Speaker: Robert E. Rutledge, ACSW. CME Credit: 35 hrs. AMA Cat. 1. Fee: \$130. Reg. Limit: 24. Sponsor, contact: The Family Institute of Chicago/Center for Family Studies, Ten East Huron, Chicago, IL 60611. Attn: Belinda Stone. Telephone: (312) 440-1414. Co-sponsors: Institute of Psychiatry, Northwestern Memorial Hospital and Northwestern University Medical School.

### Medical/Surgical

**FOURTEENTH MEDICAL/SURGICAL SEMINAR FOR LAKE COUNTY**  
For: Physicians, Dentists, Nurses, Pharmacists. Seminar/Symposium. July 27, 8:30 AM-12:30 PM. Mother Leonard Auditorium, St. Therese Hospital, 2615 Washington, Waukegan, IL 60085. Speakers: Irving M. Bush, M.D., Armand Littman, M.D., Howard Michaels, M.D. CME Credit: 4 hrs. AMA Category 1. 4 hrs. AAFP Elective; 4 hrs. AOA credit. Fee: None. Reg. Deadline: July 25, 1977. Contact: St. Therese Hospital. Contact: R. M. Adelman, D.D.S., M.D., V.P.-Med. Affairs. Telephone: (312) 588-6461.

### Sports Medicine

**SPORTS MEDICINE SEMINAR**  
For: Family Physicians, Internists. 3 day seminar and workshop. July 28 and 29, 8:00 AM to 5:00 PM; July 30, 8:00 AM to 12:00 noon. Northwestern Univ. Norris Center, 1999 Sheridan Ave., Evanston, IL. Speaker: Donald L. Cooper, M.D. CME Credit: 18 hrs. AMA Category 1. Fee: \$25.00. Reg. Deadline: June 15, 1977. Sponsor: Northwestern Univ. Medical Sch. Student Health Svc., 633 Emerson St., Evanston, IL 60201. Telephone: (312) 649-8618. Co-Sponsor: American College Health Association.

### Surgery

**ADVANCED PERIPHERAL VASCULAR SURGERY**  
For: Surgeons. Lecture. July 18, 1977. Chicago. Speaker: Robert J. Baker, M.D. CME Credit: 40 hrs. AAFP Elective, 40 hrs. AMA Category 1. Fee: \$225.00. Reg. Limit: 60. Sponsor: Cook County Graduate School of Medicine, 707 S. Wood St., Chgo. Contact: Robert J. Baker, M.D. Telephone: (312) 733-2800.

## AUGUST

### Cytology

**"WORKSHOPS IN DIAGNOSTIC CYTOLOGY--1977"**  
For: Pathologists & Cyto technologists. 5 day workshop. August 8-12, 9:00 AM-5:00 PM daily, 828 S. Wolcott, Chicago. Speaker: Dr. Elizabeth McGrew. CME Credit: 35 hrs. Fee: \$200.00. Reg. Deadline: July 26, 1977. Reg. Limit: 60. Sponsor: University of Illinois College of Medicine, Veterans Administration West Side Hosp., 1853 W. Polk St., Chgo. Contact: InAnn Kohn. Telephone: (312) 996-8025.

### Family Medicine

**SPECIALTY REVIEW FOR FAMILY PRACTICE**  
Lecture. August 15, 1977, 10% days, Cook County Graduate School of Medicine, 707 S. Wood St., Chicago. Speaker: Harry Marchmont-Robinson, M.D. CME Credit: AAFP Elective, AMA Category 1. Fee: \$350.00. Reg. Limit: 150. Sponsor: Cook County Graduate School of Medicine. Contact: Robert J. Baker, M.D. Telephone: (312) 733-2800.

### Orthopaedics

**SPECIALTY REVIEW IN ORTHOPAEDICS**  
Lecture. August 31, 1977. One week, Cook County Graduate School of Medicine, 707 S. Wood St., Chicago. Speaker: Peter C. Altner, M.D. CME Credit: AAFP Elective, AMA Category 1. Fee: \$250.00. Reg. Limit: 360. Sponsor: Cook County Graduate School of Medicine. Contact: Robert J. Baker, M.D. Telephone: (312) 733-2800.

### Sports Medicine

**SPORTS MEDICINE SEMINAR 4th ANNUAL**  
For: Coaches, Trainers and Physicians. Seminar. August 12, 5:00 PM to 11:00 PM. Ramada Inn, Champaign, IL 61820. Speaker: Don Cooper, M.D. CME Credit: None. Fee: \$10.00. Sponsor: Carle Foundation Hospital, 611 W. Park St., Urbana, IL. Contact: E. P. Grogg, M.D., Carle Clinic, 602 W. University, Urbana, IL. Telephone: (217) 337-3346. Co-sponsor: Illinois Chapter of American Academy of Podiatrists.

## SEPTEMBER

### Gynecology

**COURSE IN SPECIAL GYNECOLOGIC PATHOLOGY**  
For: Gynecologists. Lecture. September 25, one-week. Cook County Graduate School of Medicine, 707 S. Wood St., Chicago, IL 60612. Speaker: John G. Masterson, M.D. CME Credit: AAFP, AMA Category 1. American College of Obstetrics & Gynecology. Fee: \$300.00. Reg. Limit: 30. Sponsor: Cook County Graduate School of Med. Contact: Robert J. Baker, M.D., Dean. Telephone: (312) 733-2800.

### Health Professions Educ.

**ONE-YEAR GRADUATE PROGRAM--MASTER OF HEALTH PROFESSIONS EDUCATION**  
For: Physicians and Allied Health Professionals. One-year graduate program, beginning in September. University of Illinois-Medical Center Campus. Credit: Master of Health Professions. Fee: University of Illinois tuition. Sponsor: Center for Educational Development. Contact: Nancy Runkle, Center for Educational Development, 835 S. Wolcott, Rm. E106 MSA, Chicago, IL 60612. Telephone: (312) 996-3590.

### Internal Medicine

**SPECIALTY REVIEW COURSE IN CARDIOVASCULAR DISEASE**  
For: All Physicians. Lecture. September 26, 5 days-9 hours. Cook County Graduate School of Medicine, 707 S. Wood St., Chgo., IL 60612. Speaker: John Demakis, M.D. (Coordinator). CME Credit: AAFP Elective. Fee: \$200.00. Reg. Limit: 250. Sponsor: Cook County Graduate School of Medicine. Contact: Robert J. Baker, M.D., Dean. Telephone: (312) 733-2800.

### Internal Medicine

**SPECIALTY REVIEW COURSE IN ENDOCRINOLOGY**  
For: All Physicians. Lecture. September 12, 5 days-8 hours. Cook County Graduate Sch. of Med., 707 S. Wood St., Chgo., IL 60612. Speaker: Sheldon S. Walstein, M.D. (Coordinator). CME Credit: AAFP Elective and AMA Category 1. Fee: \$200.00. Reg. Limit: 100. Sponsor: Cook County Graduate Sch. of Med. Contact: Robert J. Baker, M.D., Dean. Telephone: (312) 733-2800.

### Internal Medicine

**SPECIALTY REVIEW COURSE IN GASTROENTEROLOGY**  
For: All Physicians. Lecture. September 12, 5 days-8 hours. Cook County Graduate Sch. of Med., 707 S. Wood St., Chgo., IL 60612. Speaker: Ruven Levitan, M.D. (Coordinator). CME Credit: AAFP Elective and AMA Category 1. Fee: \$200.00. Reg. Limit: 200. Sponsor: Cook County Graduate Sch. of Med. Contact: Robert J. Baker, M.D., Dean. Telephone: (312) 733-2800.

### Internal Medicine

**SPECIALTY REVIEW COURSE IN MEDICAL ONCOLOGY**  
For: All Physicians. Lecture. September 12, 5 days-8 hours. Cook County Graduate Sch. of Med., 707 S. Wood St., Chgo., IL. Speaker: William deWys, M.D. (Coordinator). CME Credit: AAFP Elective and AMA Category 1. Fee: \$200.00. Reg. Limit: 100. Sponsor: Cook County Graduate Sch. of Medicine. Contact: Robert J. Baker, M.D., Dean. Telephone: (312) 733-2800.

### Internal Medicine

**STATE & NATIONAL BOARD REVIEW COURSE, BASIC**  
For: All Physicians. Lecture. September 25-October 1, 9 hours. Cook County Graduate Sch. of Med., 707 S. Wood St., Chgo., IL 60612. Speaker: Sheldon S. Walstein, M.D. (Coordinator). CME Credit: AAFP Prescribed and AMA Category 1. Fee: \$225.00. Reg. Limit: 150. Sponsor: Cook County Graduate Sch. of Med. Contact: Robert J. Baker, M.D., Dean. Telephone: (312) 733-2800.



# FLUIDS AND ELECTROLYTES

For: All Physicians. Lecture. September 26, One Week. Cook County Graduate School of Med., 707 S. Wood St., Chgo., IL 60612. Speaker: Robert J. Baker, M.D., (Coordinator). CME Credit: AAFP Elective and AMA Category 1. Fee: \$200.00. Reg. Limit: 50. Sponsor: Cook County Graduate Sch. of Med. Contact: Robert J. Baker, M.D., Dean. Telephone: (312) 733-2800.

## Neurology

### NEUROLOGY, PART II, CLINICAL

For: All Physicians. Lecture. September 26, One Week. Cook County Graduate School of Med., 707 S. Wood St., Chgo., IL 60612. Speaker: Catherine Haselard, M.D., (Coordinator). CME Credit: AAFP Elective and AMA Category 1. Fee: \$225.00. Reg. Limit: 150. Sponsor: Cook County Graduate Sch. of Med. Contact: Robert J. Baker, M.D., Dean. Telephone: (312) 733-2800.

## Psychiatry

### SEXUAL MEDICINE

For: All Physicians. Lecture. September 26, Cook County Graduate Sch. of Med., 707 S. Wood St., Chgo., IL 60612. Speaker: Doreena Renshaw, M.D., (Coordinator). CME Credit: AAFP Prescribed and AMA Category 1. Fee: \$225.00. Reg. Limit: 100. Sponsor: Cook County Graduate Sch. of Medicine. Contact: Robert J. Baker, M.D., Dean. Telephone: (312) 733-2800.

## AMERICAN COLLEGE OF RADIOLOGY OFFERS NEW A-V TAPE SERIES

The series, eligible for AMA Category 1 CME credit, includes: The Radiology of the Pharynx A Plain Film Approach to Pulmonary Venous Obstruction Inflammatory Disease of the Colon Intestinal Diseases of the Lung Arthritides and Allied Disorders Sella Turcica Intestinal Obstruction in the Newborn

Details on prices, rental arrangements, and equipment specifications are available from:

American College of Radiology  
6900 Wisconsin Avenue  
Chevy Chase, MD 20015

## CME Planning Aids

ICCMC continually develops a variety of "how-to" material for CME Planners—DME's, program chairmen of hospitals and medical societies (both specialty and geographic), and others. All items are FREE to Illinois physicians and CME sponsors.

To learn what's currently available, request the "CME Planning Aids Order Form"; write or call . . .

Illinois Council/CME  
55 E. Monroe St., Suite 3510  
Chicago, IL 60603  
(312) 236-6110

## Challenge for CME Planners

Since Paul Sanazaro's "Medical Audit, Continuing Medical Education and Quality Assurance" appeared last September (*Western J Med*)—it has stimulated a new national debate on CME. One of his remarks: "CME does less than commonly believed to improve care." (He also points to ways of combining CME with medical audit to improve both CME and patient care.)

ICCMC has just obtained permission to reproduce copies for Illinois physicians and CME sponsors. Any CME Committee will find this paper a stimulating self-learning experience—used as the text for a discussion session or two. If you and your colleagues can't resolve to your own satisfaction the issues Sanazaro raises—take that as evidence of the need to re-think goals, objectives, methods, and evaluation procedures presently used.

For FREE copies of the Sanazaro paper, just write "SANAZARO, Box J" on your prescription form and mail to:

Box J  
Illinois Council on CME  
55 E. Monroe St.  
Chicago, IL 60603

## Director of Self-Assessment Programs for Physicians

Newly published by the AMA Dept. of Physicians Credentials and Qualifications. The third edition of the publication covers 24 programs sponsored and distributed by medical organizations.

Cost of publication (OP 414) is \$1.25 each for 1-10 copies; \$1 each for 11-49 copies; and 50¢ each for 50 or more.  
Contact: AMA Order Dept.

## CANCER INFORMATION SERVICE FOR ILLINOIS

800-972-0586

Illinois physicians may call this toll-free number for quick, easy access to a panel of cancer specialists for specific patient consultation.

Sponsored by:  
Illinois Cancer Council  
37 South Wabash Avenue  
Chicago, IL 60603

## ATTENTION: CME PLANNERS

ICCMC can help you build a high-quality CME program, worthy of accreditation, to help your colleagues satisfy the new Illinois Mandatory CME Law.

ICCMC offers:

*How to Start a CME Program* and other publications

Informal consultation by our staff  
The "Workshop on CME Leadership" for leaders of hospital medical staffs and medical societies  
The Illinois Hospital CME Consultation Service

Take advantage of your State Society's unique Council. For information, write or call:

Illinois Council/CME  
55 E. Monroe, Suite 3510  
Chicago, IL 60603  
(312) 236-6110

*HEARTBEAT*, a monthly medical publication for laymen, supported by the Heart Fund of the Chicago Heart Association, is available to any MD who requests it.

Multiple copies of each issue can be obtained to hand out to heart patients or put in the waiting room. Contact:

Jack Ruane, Editor,  
HEARTBEAT  
Chicago Heart Association  
20 North Wacker Drive  
Chicago, IL 60606  
(312) 346-4675

## Would an Outside View Help your Hospital CME?

The Illinois Hospital CME Consultation service can improve your in-hospital CME by helping you to build an up-to-date conception designed to enhance individual physicians' full clinical potential—and discard stereotyped group efforts to "keep up." The two-part process begins with self-analysis using a unique 16-page booklet—FREE to Illinois hospitals. The second part involves a personal visit and report by an expert on effective in-hospital CME; for the Consultant's visit, a modest charge is necessary to cover his honorarium, travel, and related costs.

For full information, ask for the "Consultation booklet"; write or call . . .

Illinois Council/CME  
55 E. Monroe St., Suite 3510  
Chicago, IL 60603  
(312) 236-6110



Travel Medical Seminar for all Members and Families of

# ILLINOIS STATE MEDICAL SOCIETY

## Black Sea/Greek Isles

## Air/Sea Cruise

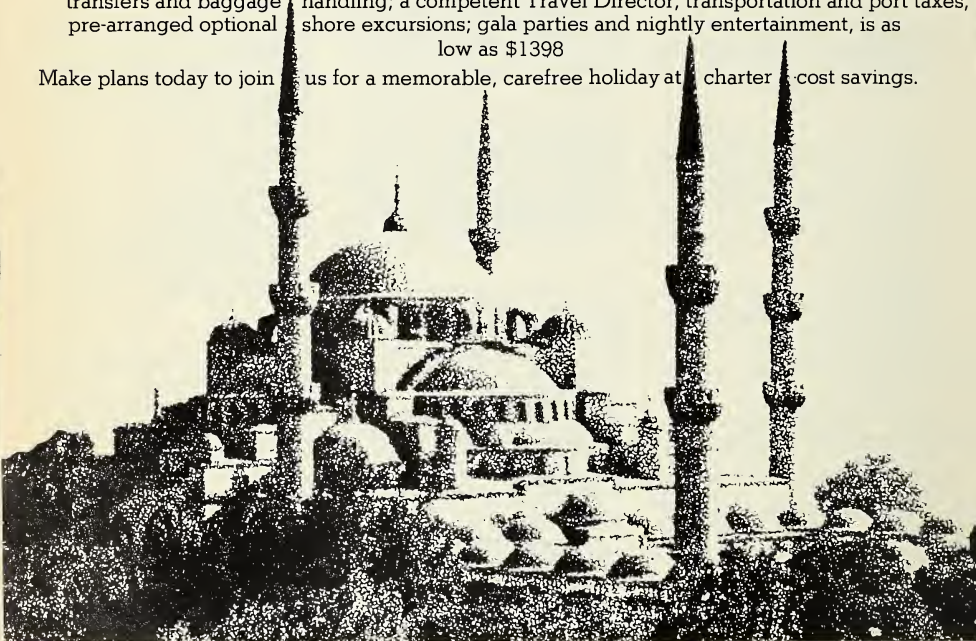
Come join us on a deluxe cruise that includes Athens and the Greek isles, throbbing Istanbul, beach resorts along the Russian Riviera, and Romania with an optional excursion to Bucharest, the "Paris of the Balkans."

**We depart Chicago On September 23 And return on October 6**

Never will your travel dollars have been spent so wisely.

Cost for the entire vacation, which includes round-trip airfare via chartered jet; comfortable staterooms aboard prestigious Sun Line's Stella Oceanis; gourmet dining; transfers and baggage handling; a competent Travel Director; transportation and port taxes; pre-arranged optional shore excursions; gala parties and nightly entertainment, is as low as \$1398

Make plans today to join us for a memorable, carefree holiday at charter cost savings.



Send to: Illinois State Medical Society  
55 East Monroe  
Chicago, Illinois 60603

(B.S.C.—9/23-10/6/77)

Enclosed is my check for \$ \_\_\_\_\_ (\$100  
per person) as deposit.

Name(s) \_\_\_\_\_  
(LAST) (FIRST) (SPOUSE)

Home Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

A Non-Regimented **INTRAV** Deluxe Adventure

# INDEX TO VOLUME 151

January through June, 1977

<b>January</b>	<b>Page 1-76</b>
<b>February</b>	<b>77-148</b>
<b>March</b>	<b>149-232</b>
<b>April</b>	<b>233-310</b>
<b>May</b>	<b>311-396</b>
<b>June</b>	<b>397-498</b>

## A

### ABSTRACTS OF BOARD OF TRUSTEES ACTIONS

10, 238, 405  
 Actions of the Department of Registration and Education  
 Medical Disciplinary Board (**SPECIAL ARTICLE**)  
 187

### ACTIONS ON RESOLUTIONS, ISMS House of Delegates

1976 Interim Session 55  
 1977 Annual Meeting 467

Acute and Chronic Management of Children with Sick  
 Cell Anemia and Cerebrovascular Occlusive Crisis  
 (Secler, Royal) 267

Adolescent Solvent Abuse (Thornton) 39  
 Adrenal Tumor, Case Report (**SURGICAL GRAND  
 ROUNDS**) John M. Beal, *Editor* 128

Agarwala, B., *jt. author*, Anomalous Origin of the Left  
 Coronary Artery From the Main Pulmonary Artery  
 (Agarwala, Thomas, Bharati) 437

Agarwala, R., *jt. author*, Anomalous Origin of the Left  
 Coronary Artery From the Main Pulmonary Artery  
 (Agarwala, Thomas, Bharati) 437

Alcoholism—Outpatient and Follow-Up Treatment in a  
 General Hospital (**SPECIAL ARTICLE**) (Cooley) 135

American Association of Medical Assistants, Illinois So-  
 ciety 66, 99, 225, 304, 338, 482

Amine, Abdul R. C., *jt. author*, Pseudomonas Lumbar  
 Diskitis (Salazar) 110

Anagnostopoulos, C. E., *jt. author*, Cardiac Valve Replace-  
 ment: Improved Survival Related to Air Exclusion and  
 Myocardial Protection (Balderman, Bates) 113

Anomalous Origin of the Left Coronary Artery From the  
 Main Pulmonary Artery (Agarwala, Agarwala, Thomas,  
 Bharati) 437

Attempted Suicide, Propanolol in (Boba, Peart) 181

## B

Balderman, S. C., *jt. author*, Cardiac Valve Replacement:  
 Improved Survival Related to Air Exclusion and Myo-  
 cardial Protection (Bates, Anagnostopoulos) 113

Bates, R. J., *jt. author*, Cardiac Valve Replacement: Im-  
 proved Survival Related to Air Exclusion and Myocar-  
 dial Protection (Balderman, Anagnostopoulos) 113

Beal, John M., *Editor* (**SURGICAL GRAND ROUNDS**)  
 44, 128, 272, 375, 443

Bharati, S., *jt. author*, Anomalous Origin of the Left  
 Coronary Artery From the Main Pulmonary Artery  
 (Agarwala, Agarwala, Thomas) 437

Bishop, Roger (**SPECIAL ARTICLE**) Contraceptive  
 Knowledge and Customs: A Study 293

Board of Trustees (**ABSTRACTS OF THE BOARD  
 ACTIONS**) 10, 238, 405

Boba, Antonio, *jt. author*, Propanolol in Attempted Sui-  
 cide (Peart) 181

## C

Caprini, Joseph, *jt. author*, Unusual Popliteal Mass (Hill,  
 Dawson) 117

Cardiac Valve Replacement: Improved Survival Related  
 to Air Exclusion and Myocardial Protection (Balder-  
 man, Bates, Anagnostopoulos) 113

Cleveland, Joseph C., Simultaneous Open Heart Surgery  
 in Combination with other Surgical Procedures 274

**CLINICS FOR CRIPPLED CHILDREN** 47, 100, 174,  
 246, 337, 423

Cocartation of the Aorta, Case Report (**SURGICAL GRAND ROUNDS**) John M. Beal, *Editor* 375

Colon Polyps, Physical Characteristics as a Determinant of Rational Management (Gunn) 270

Congenital Syphilis with Unusual Clinical Presentations: Value of Bone Roentgenograms in Diagnosis (Harris, Jimenez, Vidyagar) (**PEDIATRIC PERPLEXITIES**) Ruth M. Seeler, *Editor* 371

Contraceptive Knowledge and Customs: A Study (**SPECIAL ARTICLE**) (Bishop) 293

Continuing Medical Education, ISMS Guide to, 48, 140, 229, 302, 392, 490

Constitution, Our Greatest Ally (**PRESIDENT'S PAGE**) (Skom) 61

**CONVENTION HIGHLIGHTS**, 1977 Annual Meeting: 1977-78 Officers and Trustees 452, Highlights of Convention 453, Summary of House of Delegates Actions 461, Actions on Resolutions 467

**CONVENTION HIGHLIGHTS**, 1976 Interim Session: Summary of House of Delegates Actions 51, Actions on Resolutions 55

**CONVENTION HANDBOOK**, 1977 Annual Meeting: Members of the House of Delegates 195, Delegates and Alternate Delegates 196, County Medical Society Officers 198, Program Summary by Days 203, Auxiliary Agenda 204, House of Delegates Agenda 205, Committees of the House of Delegates 207, Resolutions 209

Cooley, Helen K. (**SPECIAL ARTICLE**) Alcoholism—Outpatient and Follow-Up Treatment in a General Hospital 135

Coronary Artery From the Main Pulmonary Artery, Anomalous Origin of the Left, (Agarwala, Agarwala, Thomas, Bharati) 437

Correct Positioning of the Endotracheal Tube (Libman) 384

Crain, Sidney M., *jt. author*, Nonfunctional Retroperitoneal Extra-Adrenal Paraganglioma (Mukhopadhyay) 257

Current Treatment of Essential Hypertension (Johnston) 25

## D

Dawson, William J., *jt. author*, Unusual Popliteal Mass (Hill, Caprini) 117

Decerebrate Patient: Eighteen Years of Care (Field, Romanus) 121

DeHaen, Paul (**NEW PHARMACEUTICAL SPECIALTIES**) 69, 145, 300, 340, 430

Dewald, Ronald L., *jt. author*, School Screening for Scoliosis (Newman) 31

Diabetic Retinopathy, Effective Treatment of (Morse) 103

Diagnostic Uses for Ultrasonography (Smith) 382

**DOCTOR, WHAT'S YOUR OPINION?** 38

**DOCTOR'S NEWS** 59, 131, 191, 277, 363, 449

## E

### EDITORIALS

Good Luck, Dr. Ted 8

Autogenous Conversation 156

The Public Demand—or the Public be Damned? 411

### EDITORIALS, GUEST

Visiting Professor Program 68

Legal Rights vs. Patients Needs 86

Illinois Mental Health Code: Proposals and Problems 366

Effective Treatment of Diabetic Retinopathy (Morse) 103

**EKG OF THE MONTH** (John R. Tobin, Jr., Rimgaudas Nemickas, Patrick J. Scanlon, John F. Moran, Sarah Johnson, Rolf Gunnar) 17, 101, 166, 242, 321, 424

Emanuel, Benjamin, *jt. author*, Teething in Infancy: A Part of Normal Development (Kravitz, Kasper, Neyhus) 261

Encephalitis (St. Louis), Clinical Course and Response to Corticosteroids (Sauer) 183

Endotracheal Tube, Correct Positioning of the (Libman) 384

## F

Field, Robert E., *jt. author*, A Decerebrate Patient: Eighteen Years of Care (Romanus) 121

Foreign Bodies in the Gastrointestinal Tract (**SURGICAL GRAND ROUNDS**) John M. Beal, *Editor* 443

Fraud (**PRESIDENT'S PAGE**) (Skom) 133

## G

Gastrointestinal Tract, Foreign Bodies in the, (**SURGICAL GRAND ROUNDS**) John M. Beal, *Editor* 443

Giant Diverticulum of Sigmoid, Case Report (**SURGICAL GRAND ROUNDS**) John M. Beal, *Editor* 272

Group B Beta Hemolytic Streptococcal Infection in Neonates (Turner, Keeney) 177

Gunn, Larry C., Physical Characteristics of Colon Polyps as a Determinant of Rational Management 270

Gunnar, Rolf M., (**SEE EKG OF THE MONTH**)

## H

Harris, Vivian J., *jt. author*, (**PEDIATRIC PERPLEXITIES**) Congenital Syphilis with Unusual Clinical Presentations: Value of Bone Roentgenograms in Diagnosis, (Jimenez, Vidyagar) 371

Hill, J. Laurance, *jt. author*, Increased Safety in Renal Transplantation (Simonian, Stuart) 21

Hill, James, *jt. author*, Unusual Popliteal Mass (Caprini, Dawson) 117

Hirano, Takeki, *jt. author*, (**PEDIATRIC PERPLEXITIES**) Vitamin D Poisoning from Ingestion of Concentrated Vitamin D Used to Fortify Milk (Janakiraman, Rosenthal) 418

Heiser, William J., *jt. author*, Pelvic Lipomatosis (Norfray, Schlachter) 125

Hospital Admission Surveillance Program, Medical Care Evaluation Studies Under the (**SPECIAL ARTICLE**) (White) 355

Hyperparathyroidism in a Patient with Thyroid Hemangioma (Maganini, Narendran) 368

Hyperpyrexia, Ultrastructure of Skeletal Muscle in a Case of Malignant, (Navas) 433

Hypertension, Current Treatment of Essential (Johnston)  
25

## I

**ILLINOIS MEDICAL POLITICAL ACTION COMMITTEE** 6, 124, 158, 254, 333, 472

**ILLINOIS SOCIETY, AMERICAN ASSOCIATION OF MEDICAL ASSISTANTS** 66, 99, 225, 304, 338, 482

Impaired Physician, The Panel for the (**SPECIAL ARTICLE**) 286

Increasing Abuse of Phencyclidine (Showalter, Thornton) 387

Increased Safety in Renal Transplantation (Hill, Simonian, Stuart) 21

**ISMS GUIDE TO CONTINUING MEDICAL EDUCATION** 48, 140, 229, 302, 392, 490

**ISMS HOUSE OF DELEGATES**

Actions on Resolutions, 1976 Interim Session 55

Actions on Resolutions, 1977 Annual Meeting 467

Summary of Actions, 1976 Interim Session 51

Summary of Actions, 1977 Annual Meeting 461

ISMS Leadership Conference 90

## J

Janakiraman, Natesan, *jt. author*, (**PEDIATRIC PERPLEXITIES**) Vitamin D Poisoning from Ingestion of Concentrated Vitamin D Used to Fortify Milk (Hirano, Rosenthal) 418

Jimenez, Carlos A., *jt. author* (**PEDIATRIC PERPLEXITIES**) Congenital Syphilis with Unusual Clinical Presentations: Value of Bone Roentgenograms in Diagnosis (Harris, Vidyasagar) 371

Johnson, Sarah (**SEE EKG OF THE MONTH**)

Johnson, Louis C., Current Treatment of Essential Hypertension 25

## K

Kaplan, Paul E., Rheumatoid Myopathy 106

Kasper, Joseph, *jt. author*, Teething in Infancy: A Part of Normal Development (Kravitz, Emanuel, Neyhus) 261

Keeney, Ronald E., *jt. author*, Group B Beta Hemolytic Streptococcal Infection in Neonates (Turner) 177

Kravitz, Harvey, *jt. author*, Teething in Infancy: A Part of Normal Development (Emanuel, Kasper, Neyhus) 261

## L

Libman, Robert H., Correct Positioning of the Endotracheal Tube 384

Liver Tumor, Case Report (**SURGICAL GRAND ROUNDS**) John M. Beal, *Editor* 44

Love, Leon, *Editor* (**VIEWBOX**) 42, 170, 252, 328

## M

Maganini, Robert J., *jt. author*, Hyperparathyroidism in a Patient with Thyroid Hemangiogenesis (Narendran) 368

McGuinness, Brian W., (**SPECIAL ARTICLE**) Night Calls in Family Practice 360

Medical Evaluation Studies Under the Hospital Admission and Surveillance Program (**SPECIAL ARTICLE**) (White) 355

Medical Disciplinary Board, Department of Registration and Education, Actions of (**SPECIAL ARTICLE**) 187

**MEMBERSHIP FORUM** 65, 92, 220, 298, 342

Moran, John F., (**SEE EKG OF THE MONTH**)

Moretti, Joan, Who Graduated This Spring? 484

Morse, Peter H., Effective Treatment of Diabetic Retinopathy 103

Mukhopadhyay, Dipankar, *jt. author*, Nonfunctional Retroperitoneal Extra-Adrenal Paraganglioma (Crain) 257

## N

Narendran, K., *jt. author*, Hyperparathyroidism in a Patient with Thyroid Hemangiogenesis (Maganini) 368

Navas, Jose J., Ultrastructure of Skeletal Muscle in a Case of Malignant Hyperpyrexia 433

Nemickas, Ringaudas (**SEE EKG OF THE MONTH**)

Neonates, Group B Beta Hemolytic Streptococcal Infection in, (Turner, Keeney) 177

**NEW PHARMACEUTICAL SPECIALTIES** (DeHaen) 69, 145, 300, 340, 430

Newman, Daniel C., *jt. author*, School Screening for Scoliosis (DeWald) 31

Neyhus, Arthur, *jt. author*, Teething in Infancy: A Part of Normal Development (Kravitz, Emanuel, Kasper) 261

Night Calls in Family Practice (**SPECIAL ARTICLE**) (McGuinness) 360

Nonfunctional Retroperitoneal Extra-Adrenal Paraganglioma (Mukhopadhyay, Crain) 257

Norfray, Joseph F., *jt. author*, Pelvic Lipomatosis (Schlachter, Heiser) 125

## O

**OBITUARIES** 18, 96, 172, 246, 324, 487

Open Heart Surgery in Combination with other Surgical Procedures, Simultaneous (Cleveland) 274

Opinion Poll 38

## P

Panel for the Impaired Physician (**SPECIAL ARTICLE**) 286

Peart, Kenneth A., *jt. author*, Propanolol in Attempted Suicide (Boba) 181

**PEDIATRIC PERPLEXITIES**, Ruth A. Secler, *Editor*

Congenital Syphilis with Unusual Clinical Presentations: Value of Bone Roentgenograms in Diagnosis (Harris, Jimenez, Vidyasagar) 371

Vitamin D Poisoning from Ingestion of Concentrated Vitamin D Used to Fortify Milk (Hirano, Janakiraman, Rosenthal) 418

Pelvic Lipomatosis (Norfray, Schlachter, Heiser) 125

Phencyclidine, Increasing Abuse of (Showalter, Thornton) 387

Physical Characteristics of Colon Polyps as a Determinant of Rational Management (Gunn) 270

**PHYSICIAN RECRUITMENT PROGRAM, ISMS**, 72, 142, 226, 306, 350, 488



Poisoning from Ingestion of Concentrated Vitamin D Used to Fortify Milk, Vitamin D, **(PEDIATRIC PERPLEXITIES)** (Hirano, Janakiraman, Rosenthal) Ruth A. Secler, *Editor* 418

Popliteal Mass, Unusual (Hill, Caprini, Dawson) 117

## PRESIDENT'S PAGE

The Constitution, Our Greatest Ally (Skom) 61

Fraud (Skom) 133

Responsibility Before the Vote (Wilkins) 448

"We Have Met the Enemy and They Is Us" (Skom) 190

What Do We Want? (Skom) 279

Who Are "Those Guys"? (Wilkins) 365

Propanolol in Attempted Suicide (Boba, Peart) 181

Pseudomonas Lumbar Diskitis (Amine, Salazar) 110

Pulmonary Artery, Anomalous Origin of the Left Coronary Artery from the Main, (Agarwala, Agarwala, Thomas, Bharati) 437

**PULSE OF THE DOCTOR'S WIFE** 71, 144, 219, 292, 390, 473

## R

Renal Transplantation, Increased Safety in (Hill, Simonian, Stuart) 21

Responsibility Before the Vote **(PRESIDENT'S PAGE)** (Wilkins) 448

Retroperitoneal Extra-Adrenal Paraganglioma, Nonfunctional (Mukhopadhyay, Crain) 257

Rheumatoid Myopathy (Kaplan) 106

Romanus, Raymond J., *jt. author*, A Decerebrate Patient: Eighteen Years of Care (Field) 121

Rosenthal, Ira M., *jt. author*, **(PEDIATRIC PERPLEXITIES)** Vitamin D Poisoning from Ingestion of Concentrated Vitamin D Used to Fortify Milk (Janakiraman, Hirano) 418

Royal, Joyce E., *jt. author*, Acute and Chronic Management of Children with Sickle Cell Anemia and Cerebrovascular Occlusive Crisis (Secler) 267

## S

Salazar, Jose L., *jt. author*, Pseudomonas Lumbar Diskitis (Amine) 110

Sauer, Curtis M., St. Louis Encephalitis: Clinical Course and Response to Corticosteroids 183

Scanlon, Patrick J. **(SEE EKG OF THE MONTH)**

Schlachter, Lawrence, *jt. author*, Pelvic Lipomatosis (Norfray, Heiser) 125

Scoliosis, School Screening for (Newman, DeWald) 31

Secler, Ruth Andrea, *Editor* **(PEDIATRIC PERPLEXITIES)** 371, 418; *jt. author*, Acute and Chronic Management of Children with Sickle Cell Anemia and Cerebrovascular Occlusive Crisis (Royal) 267

Showalter, Craig V., *jt. author*, The Increasing Abuse of Phencyclidine (Thornton) 387

Sickle Cell Anemia and Cerebrovascular Occlusive Crisis, Acute and Chronic Management of Children with (Secler, Royal) 267

Simonian, Simon J., *jt. author*, Increased Safety in Renal Transplantation (Hill, Stuart) 21

Simultaneous Open Heart Surgery in Combination with other Surgical Procedures (Cleveland) 274

Skom, Joseph H. **(PRESIDENT'S PAGE)** 61, 133, 190, 279

Smith, Robert P., Diagnostic Uses for Ultrasonography 382

St. Louis Encephalitis: Clinical Course and Response to Corticosteroids (Sauer) 183

Stuart, Frank P., *jt. author*, Increased Safety in Renal Transplantation (Hill, Simonian) 21

**SUMMARY OF ACTIONS**, ISMS House of Delegates 1976 Interim Session 51  
1977 Annual Meeting 461

**SURGICAL GRAND ROUNDS**, John M. Beal, *Editor*

Case Report: Liver Tumor 44

Case Report: Adrenal Tumor 128

Case Report: Giant Diverticulum of Sigmoid 272

Case Report: Coarctation of the Aorta 375

Foreign Bodies in the Gastrointestinal Tract 443

## T

Teething in Infancy: A Part of Normal Development (Kravitz, Emanuel, Kasper, Neyhus) 261

Thomas, W., Jr., *jt. author*, Anomalous Origin of the Left Coronary Artery from the Main Pulmonary Artery (Agarwala, Agarwala, Bharati) 437

Thornton, William C., Adolescent Solvent Abuse 39; *jt. author*, The Increasing Abuse of Phencyclidine (Showalter) 387

Tobin, John R. **(SEE EKG OF THE MONTH)**

Turner, Ronald, *jt. author*, Group B Beta Hemolytic Streptococcal Infection in Neonates (Keeney) 177

## U

Ultrasonography, Diagnostic Uses for (Smith) 382

Ultrastructure of Skeletal Muscle in a Case of Malignant Hyperpyrexia (Navas) 433

Unusual Popliteal Mass (Hill, Caprini, Dawson) 117

## V

Vidyasagar, Dharmapuri, *jt. author*, **(PEDIATRIC PERPLEXITIES)** Congenital Syphilis With Unusual Clinical Presentations: Value of Bone Roentgenograms in Diagnosis (Harris, Jimenez) 371

**VIEWBOX**, Leon Love, *Editor* 42, 170, 252, 328

Vitamin D Poisoning from Ingestion of Concentrated Vitamin D Used to Fortify Milk **(PEDIATRIC PERPLEXITIES)** (Hirano, Janakiraman, Rosenthal) Ruth A. Secler, *Editor* 418

## W

"We Have Met the Enemy and They Is Us" **(PRESIDENT'S PAGE)** (Skom) 190

What Do We Want? **(PRESIDENT'S PAGE)** (Skom) 279

White, Fred Z. **(SPECIAL ARTICLE)** Medical Care Evaluation Studies Under the Hospital Admission and Surveillance Program 355

Who Are "Those Guys"? **(PRESIDENT'S PAGE)** (Wilkins) 365

Who Graduated This Spring? (Moretti) 484

Wilkins, George T. **(PRESIDENT'S PAGE)** 365, 448











Illinois medical journal.  
v.151,1977.

X78-1334

RETURN THIS BOOK ON OR BEFORE LAST DATE STAMPED

RET'D. MAY 5 78

